

HEADQUARTERS
CALIFORNIA ARMY NATIONAL GUARD
SACRAMENTO, CA
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CA ARNG REGULATION 600-1
CA ANG Instruction 36-2601

MILITARY PERSONNEL ON STATE ACTIVE DUTY

FOR THE GOVERNOR:

PAUL D. MONROE JR.
MAJOR GENERAL
The Adjutant General

OFFICIAL:

FRED W. GAGE
COL., AR, CAARNG
Director of Administration



History. This regulation supercedes CAARNGR 600-1/CAANGI 36-2601 dated 1 March 2001.

Summary. This regulation establishes the Military Department's policy regarding the State Active Duty program and is provided as guidance for State Active Duty members and Department leadership.

Applicability. This regulation applies to all California State Active Duty service members.

Supplementation. Supplementation of this regulation is not authorized. Proposed changes will be directed to the Director, State Personnel Programs, for coordination prior to submission to The Adjutant General and his/her Executive Council for approval and subsequent implementation. Approved changes will be incorporated and announced as changes to this regulation.

Suggested Improvements. The Director, State Personnel Program is the proponent of this regulation. Users are invited to send comments and suggested improvements to: Office of The Adjutant General, ATTN: Director, State Personnel (CAJS-SP), P.O. Box 269101, Sacramento, CA 95826-9101.

Annual Review. All State Active Duty Instructions, changes and proposed improvements will be reviewed annually for incorporation into this regulation if appropriate. The Director of State Personnel Programs is responsible for coordinating this annual review no later than 15 June of each successive year.

Distribution. Distribution of this regulation is ARMY - A and Air Force - F.

CHAPTER 1 GENERAL

1-1. PURPOSE

- a. This regulation prescribes policies and procedures for the administration of personnel appointed to State Active Duty (SAD) under the provisions of Section 142 and/or 167, California Military and Veterans Code (CMVC).
- b. This regulation is not applicable to personnel called to State Active Duty for emergency purposes under Section 143 and 146 (CMVC). Administrative procedures for other than section 142/167 (CMVC) appointments are published separately. Refer to the Emergencies Operation Manual for Emergency State Active Duty procedures.
- c. All appointments, promotions, and personnel actions are based on equal opportunity for all to the maximum extent possible under the law.

1-2. AUTHORITY

- a. This regulation is issued under authority of Sections 52, 160, 163, and 173, California Military and Veterans Code (CMVC).
- b. The Adjutant General has authority and responsibility for the administration of the State Active Duty program to include personnel allocation and classification authority. Authority is further delegated to the Director, State Personnel Programs for day-to-day administration, policy recommendations, interagency coordination, and pay determinations related to State Active Duty positions and service members. Any other delegation of authority under this regulation by The Adjutant General shall be made in writing.
- c. The Director, State Personnel Programs shall publish State Active Duty Instructions (SADI) as necessary.

CHAPTER 2 DEFINITION OF TERMS

2-1. The following definitions pertain to terms used in this regulation:

- a. **Active Militia.** Comprised of the California Army and Air National Guard, the State Military Reserve and the Naval Militia (Section 120, CMVC). Individuals placed on the California National Guard retired list after completing twenty or more years of creditable military service, active or inactive, are considered as members of the California National Guard (CMVC 210) for employment purposes.
- b. **California Military and Veterans Code** is abbreviated **CMVC**. It is the legislative and legal authority for the State Active Duty Program.
- c. **California Public Employees Retirement System** is abbreviated **CalPERS**. It is the system under which State Active Duty personnel are afforded retirement benefits.
- d. **Established Position.** A position authorized in the governor's budget.
- e. **Indefinite Appointment.** An appointment of a service member to an established position without time limitation and exceeding six months.
- f. **Key Staff Positions.** Positions identified in Appendix B. These positions are reviewed annually.
- g. **Pay and Allowances.** Entitlements based on federal military pay rates as directed by CMVC section 320 and 321. See Department of Defense (DOD) Military Pay and Allowances Entitlements Manual, DOD 7000.14-R.

- h. Payday.* Normally the last working day of the month.
- i. Pay Grade.* Pay level authorized by the State Active Duty position grade shown in the State Active Duty Staffing Guide.
- j. Pay Warrant.* The term used to describe State of California paychecks.
- k. Personnel Year (PY).* Refers to the budgetary authorization for the filling of a position for a period of one year. PY requirements are separate and distinct from the funding requirements to fill a position.
- l. Rank.* The underlying active militia component status as signified by the insignia authorized for wear by the respective militia component (i.e. highest federally recognized grade).
- m. Reclassify.* Means to change the title, grade, and/or location of a SAD position.
- n. Retitle.* To change the title or name of a position without changing the grade or location.
- o. State Active Duty (SAD).* Pertains to the status of personnel ordered to military duty under authority of the Adjutant General in accordance with the provisions of the California Military and Veterans Code 142 or 167. For the purposes of this Regulation, State Active Duty does not include emergency state active duty under Sections 143 or 146 CMVC.
- p. State Active Duty Instructions (SADI).* An Instruction published by the Director, State Personnel Programs, to announce policy, clarify processes, and provide specific guidance to implement this Regulation.
- q. State Active Duty Staffing Guide.* The authorization document for established SAD positions in the Military Department established by the Director, State Personnel Programs, and approved by The Adjutant General.
- r. Temporary Position.* A position created to meet specific needs for a limited period of time.
- s. Temporary Appointment.* An appointment of a service member to either a temporary or established position for a period not to exceed six months with orders specifying an end date.
- t. Tenure.* A status that may be granted service members with indefinite appointments to established positions supported by the General Fund after completing a probationary period of one year. Tenure is granted under authority of Section 167, California Military and Veterans Code.
- u. Term Appointment.* An appointment of a service member to either a temporary or established position for greater than six months with orders specifying an end date.
- v. Terminal Leave.* Ordinary leave taken prior to separation.

CHAPTER 3 POSITIONS

3-1. GENERAL

- a.* All service members ordered to State Active Duty under the provisions of this regulation must be appointed to either an established or temporary position.
- b.* The military grade structure for established and temporary positions will be based as closely as possible military grades established for comparable organizations and positions within the active military services (Section 164 CMVC).

3-2. ESTABLISHED POSITIONS

- a.* Established positions are established in the Military Department Headquarters, field level activities, and units of the California Army and Air National Guard based on functional military requirements. Established positions are those identified in the Governor's budget.
- b.* A State Active Duty Staffing Guide established by the Director, State Personnel Programs and approved by The Adjutant General is the basis for State Active Duty position grades. Exceptions to the SAD Staffing Guide require the approval of The Adjutant General, and in some cases, the Legislature and/or Department of Finance.

3-3. TEMPORARY POSITIONS

Temporary positions are positions established to meet specific needs for a limited period of time. They are established for short-term work requirements and are subject to availability of temporary help funds and Personnel Year (PY) support as authorized by the Governor's Budget.

3-4. ESTABLISHED POSITION REVIEW POLICY

a. All established positions will be reviewed at least annually or when they are reclassified, retitled or become vacant. The purpose of the review is to determine if the position is properly classified or if it would be more appropriate to convert the position to State Civil Service status.

b. An annual review of positions will be conducted in June of each year. The Deputy Adjutants General and a representative designated for the Command Section will submit a statement through the Director, State Personnel Programs, and to The Adjutant General by 15 July of each year certifying that the reviews have been completed.

c. The annual statement will include a recommendation that positions either remains as established or be converted to State Civil Service.

d. The review and recommendation will be based upon organizational needs, and an overall evaluation of the requirements of the position, which must meet at least two of the following criteria:

(1) The duties of the position require military experience and current technical or operational knowledge of military procedures, plans, programs, or equipment.

(2) Full qualification in the position requires initial or periodic attendance at military schools.

(3) The duties of the position require substantive command or supervision of other military personnel (SAD, military technicians, AGR, or ADSW).

(4) The duties include command and control or supervision of military field organizations or activities.

(5) The duties or nature of the position require the ability to respond to emergencies in a military capacity.

(6) The position requires traditional military or ceremonial duties associated with military organizations or installations.

(7) Assignment of a military member in the position will enhance the continuity of operations and effectiveness of the Military Department.

(8) The use of a State Civil Service position at the appropriate classification level would not provide significant cost savings.

(9) There is an appropriate Army Military Occupational Specialty (MOS) or Air Force Specialty Code (AFSC) consistent with the duties of the position.

(10) There are military security requirements associated with the position.

3-5. ESTABLISHING, RECLASSIFYING, RETITLING OR ABOLISHING POSITIONS

a. Requests to establish reclassify and/or retitle temporary and established positions will be subject to the criteria described in paragraph 3-4 above. Requests to abolish a position are not subject to this requirement.

b. Requests to establish, reclassify, retitle, or abolish positions may require Department of Finance (DOF) approval in accordance with its directives and/or the provisions of the State Budget Act. The following actions are required:

(1) OTAG Form 900-13 (State Active Duty Position Request) will be used to establish reclassifies and retitles all positions. Each request must also be accompanied by a completed OTAG Form 900-13a (State Active Duty Position Description), OTAG Form 900-36 (Task Listing) and an organizational chart of the division, directorate or office in which the position will be located. This documentation must be submitted to the Office of State Personnel at least 30 days prior to the desired effective date.

(2) Each OTAG Form 900-13 must contain a certification that the criteria listed in paragraph 3-4d has been met as a prerequisite to establish, reclassify, or retitle the position. The certification will be entered at the bottom of item 5 (OTAG Form 900-13) and state the following: "After reviewing this position, pursuant to the criteria outlined in paragraph 3-4d, CAARNGR 600-1/CAANGI 36-2601, I conclude this position is appropriately designated an SAD temporary/established (as appropriate) position."

(3) Requests to abolish a position must be submitted on OTAG Form 900-13 and must be submitted to THE OFFICE OF STATE PERSONNEL at least 60 days prior to the desired effective date. The basis for abolishment of the position must be explained in item 5.

(4) The requesting official for item 6 on OTAG Form 900-13 (State Active Duty Position Request), will normally be directorate level supervisors, ANG Base/Station Commanders or comparable level managers.

(5) The Director, State Personnel Programs will review the OTAG Form 900-13 and if approved, the position request will be forwarded to Military Department Comptrollers Office (CAJS-SC) for fiscal authority approval. The Director, State Personnel Programs is the office of primary responsibility and will provide written authorization of the grade classification and effective date of the position to the requesting supervisor.

CHAPTER 4 APPOINTMENTS

4-1. GENERAL. There are three types of appointments:

a. Indefinite Appointment. An appointment to State Active Duty in an established position without time limitation and exceeding six months. Indefinite appointments may only be made to established positions. An established position is a position authorized in the Governor's budget.

(1) Service members with indefinite appointments are entitled to pay, allowances, and benefits, which include health, dental, vision and life insurance.

(2) Tenure is a Section 167 CMVC status that The Adjutant General may award to service members who have been appointed to a State Active Duty established position for an indefinite period only on written request of the supervisor after they have served a minimum one-year probationary period.

(a) At the end of the one-year probationary period, the supervisor may request the award of tenure for the service member.

(b) The supervisor may forward his or her favorable memorandum of recommendation and a copy of the OTAG Form 900-20 (SAD Evaluation of Performance) through the chain of command to the Director, State Personnel Programs.

(c) If approved, orders under the authority of Section 167, CMVC, shall be published and distributed by the Director, State Personnel Programs, to confirm the effective date of tenure.

b. Term Appointment. An appointment to either a temporary or established position for greater than six months with orders specifying an end date. Service members with term appointments are entitled to pay, allowances and benefits, which include health, dental, vision and life insurance.

c. Temporary Appointment. An appointment to either a temporary or established position for a period not to exceed six months with orders specifying an end date. Service members with temporary appointments are entitled to pay and allowances. Temporary appointment pay grades of retired California National Guard personnel may be paid at their last federally recognized pay grade. No other benefits are authorized except workers compensation for duty related injuries. Annual leave will be accrued if the appointment is thirty days or more. Any leave accrued during the temporary appointment must be used before the ending date on the orders. Lump sum leave payments will not be made. The unexecuted portion of temporary SAD orders may be rescinded for administrative or disciplinary reasons at any time.

4-2. APPOINTMENT QUALIFICATIONS

a. Only members of the active militia may be appointed to State Active Duty. All appointments must be either to a temporary position or an established position.

b. Individuals whose active militia rank is equal to the authorized pay grade for the position will fill these positions. Exceptions to appoint at one grade over or under based on the appointee's highest federally recognized grade may be granted by The Adjutant General on a case by case basis.

c. If an individual receives a military federally recognized promotion after appointment to a position, he or she may be retained in the position with no change in status.

d. In the event the individual was appointed to a position lower than the authorized grade because of his or her military grade, the individual, may be non-competitively reassigned to the original position. This action would normally occur once the individual had been federally promoted. Additionally, this action would occur only at the recommendation of the supervisor/chain of command provided that the authorized grade of the position is not exceeded.

e. All State Active Duty personnel are expected to meet the military medical standards and physical fitness standards appropriate for the active militia component. Exceptions may be granted by The Adjutant General based upon the recommendation of the respective State Surgeon (Army or Air). Respective Deputy Adjutants General in compliance with their military service component rules will address failures.

f. State Active Duty personnel must also be MOS/AFSC qualified and meet military educational requirements for their grade and active militia component. Exceptions may be granted by The Adjutant General on a case by case basis.

g. Individuals convicted of a felony or those released for misconduct or adverse administrative action as a result of misconduct from federal or state service, civilian or military, are not eligible for a State Active Duty appointment.

h. A request to temporarily appoint a service member to accomplish a specific project, such as develop and write a program of instruction, that is 30 days in duration will not require a separate, written position description (OTAG 900-13, 900-13a, 900-36, and organization chart) under the provisions of paragraph 3-5b(1).

(1) The project will be annotated in the remarks of the OTAG Form 900-10 to justify appointment and outline the special project.

(2) There are no extensions beyond 30 days for this type of temporary appointment.

i. Temporary appointment to a SAD position for personnel past age 60 will require Adjutant General approval and temporary appointment IAW CMVC Section 230. Each temporary appointment will be addressed on a case by case basis and requests will be forwarded to CAJS-SP for processing.

4-3. SELECTION PROCEDURE

a. Established positions will be announced in California National Guard Memorandums and distributed to California Army and Air National Guard organizations and other components of the active militia.

Temporary positions that require term appointments for more than six months must also be announced.

b. The Adjutant General may authorize an exception to the vacancy announcement policy when such an exception is fully justified and documented in writing. When positions are filled without announcement, the following statement will be entered in the remarks section of OTAG Form 900-10 "Position filled as an approved exception to announcement procedures under the provisions of paragraph 4-3 b, CAARNGR 600-1/CAANGI 36-2601". The completed form will be forwarded to the Director, State Personnel Programs prior to appointment.

c. Requests for position vacancy announcements will be submitted to the Director, State Personnel Programs for review and processing. The request will include the Position Description (OTAG Form 900-13a), Task Listing (OTAG Form 900-36) and a organizational chart indicating the relationship of the position within the current structure of the team, office, department, command, directorate, site or station. The request should also include the proposed closing date (which is normally 30 days or longer after the position has been announced) and the name and title of the selecting supervisor.

d. Applications, OTAG Form 900-8 (SAD Appointment Application) received by the Office of State Personnel Programs in response to a vacancy announcement will be reviewed for correctness and a determination that the applicant meets the basic qualifications for the position.

(1) If the number of qualified applicants is three or less, a Merit Selection Board is not required; the applications will be forwarded to the Selecting Supervisor for consideration in accordance with paragraph 4-3 d (2) below.

(2) If the number of qualified applicants is more than three, the respective Deputy Adjutants General, in consultation with the selecting supervisor will appoint a Merit Selection Board. Applications of qualified applicants will then be forwarded to the selecting supervisor, and in turn to the President of the Merit Selection Board to evaluate the applications as described below:

e. Merit Selection Boards will consist of a minimum of three members. SAD, State Civil Service (SCS), Military/Civilian Technicians, AGR, or ADSW personnel may be appointed to the board. The board members must be higher in grade than the position to be filled. Higher-grade determinations for civilians appointed to the board will be based on a comparison of the maximum salary of the civilian position versus the maximum salary including allowances of the SAD position being considered. The civilian service members' salary must be greater than the SAD salary to qualify for board membership. The selecting supervisor cannot be a member of the board.

f. A Merit Selection Board will normally include at least one member from the Section/Branch/Directorate or field level of activity where the position will be assigned.

g. The Board will review the applications, conduct interviews, and rank the applicants in recommended selection order. Applicants may be required to appear before the board unless the Director, State Personnel Programs grant a written waiver of this requirement.

h. The Board will develop a series of questions regarding the principal functions of the position and the applicant's background and experience. Each applicant will be asked the same questions. The series of questions, the Board member's interview notes and the working papers of the Merit Selection Board become part of the State Personnel Programs' selection board file and will be provided to the Director, State Personnel Programs, after completion of the selection board process.

i. After completion of the review process, the Merit Selection Board will return the applications; the selection board file documentation indicated in paragraph 4-3 h above and the recommended selection order to the Director, State Personnel Programs. The Director, State Personnel Programs will review the Board's results and forward the documents to the selecting supervisor for action.

j. The Selecting Supervisor will review the applicant packets or Board's recommendations as appropriate and select from the top three ranked individuals. When there are multiple positions announced within a single vacancy announcement, the top three list will expand by one for each additional position fill requirement; that is, if there are two positions announced, the top three list will provide the four highest reached service members for selection by the selecting supervisor. The name of the selected individual will be forwarded to the Director, State Personnel Programs for final approval processing. It is essential that announcement of the name of the selected individual not occur until other applicants have been advised of their non-selection. The Director, State Personnel Programs will advise both the selected and non-selected applicants of the selection decision within a very short period of time so that all applicants hear of the results at the same time.

CHAPTER 5 PERSONNEL ACTIONS

5-1. APPOINTMENT PROCEDURES

- a.* Submission of the OTAG Form 900-10 (State Active Duty Personnel Action Request) will initiate the appointment process. Supervisors shall not allow service members to report for duty without written authorization from the Director, State Personnel Programs.
- b.* Requests will be forwarded to the Office of State Personnel Programs at least ten working days prior to the proposed effective date. Upon receipt of written approval, the submitting supervisor is responsible for prompt submission of appointment documents. Submission requirements are outlined in State Active Duty Instructions (SADI) and are published separately. The Director, State Personnel Programs updates these instructions whenever forms or clarification is required.
- c.* State Personnel will process the appointment documents and publish State Active Duty orders.
- d.* It is the service member's responsibility to insure that office of State Personnel Programs is informed of any address changes or changes in dependency status that would affect pay or health/dental/vision entitlements and submit the appropriate updated forms when changes occur.
- e.* Information pertaining to optional payroll deductions will be provided to the individual upon completion of the appointment process.

5-2. REASSIGNMENT PROCEDURES

- a.* The reassignment process is initiated by the submission of the OTAG Form 900-10 (State Active Duty Personnel Action Request). Subordinate supervisors shall not allow service members to report for duty without prior written authorization from the Director, State Personnel Programs.
- b.* Reassignments will be initiated by the supervisor and forwarded through the chain of command to State Personnel Programs utilizing OTAG Form 900-10. Entitlement to moving expenses may result from reassignments involving relocation from the current work site. Authorized relocation will be coordinated with State Comptroller's Office (CASJ-SC).
- c.* Over-grade. If it becomes necessary to reassign a current service member to a position established at a grade lower than that to which the member is currently appointed, the request for reassignment with full justification will be forwarded to the Director, State Personnel Programs for consideration. Such reassignments will be considered as temporary and must be mitigated as soon as possible, but not longer than two years. The appropriate senior manager will insure one of the following actions occur not later than two years from the date of assignment:

- (1) Reassign the individual out of over-grade assignment.
- (2) Reevaluate over-grade assignment for continuance.
- (3) Reclassify the position, if responsibilities have changed or increased.
- (4) Take such other action necessary to alleviate the over-grade assignment.

d. Detail Action. State Active Duty members may be detailed on a temporary basis to meet mission requirements not to exceed 90 days. These personnel actions are initiated by supervisors, submitted through the Chain of Command and approved by the Director, State Personnel Programs. A detail memorandum will be provided to the affected member with copies provided to the chain of command. Only one extension of the detail action is authorized during which time alternatives such as reclassification and budget change proposal processing to establish a new requirement must be addressed.

5-3. INCUMBENT PROMOTION AND REDUCTION PROCEDURES

a. Incumbent promotion is accomplished by reassignment action and will be based upon subparagraph 4-2 d above (initial appointment one grade lower than the position grade level) or submission of a reclassification action in accordance with paragraph 3-5 above (duty position requirements have expanded beyond current duties and responsibilities).

b. Incumbent reduction is accomplished by formal discipline action in accordance with paragraph 11-4 b(3) below or by submission of a reclassification action in accordance with paragraph 3-5 above (duty position requirements have decreased beyond current duties and responsibilities).

5-4. SEPARATION PROCEDURES

a. An OTAG Form 900-28 (Service Member Clearance Form) must be completed for all service members being separated and submitted to Director, State Personnel Programs prior to issuance of final pay.

b. Orders shall be published indicating the effective date of separation and stating whether the separation is voluntary or involuntary. Separation is not effective until delivery of the order to the individual has been accomplished.

c. Mandatory Separation.

(1) Service members on State Active Duty with Indefinite Appointment to an established position other than The Adjutant General, Assistant Adjutant General or Deputy Adjutant General, and other than those physically disqualified or separated for cause, may remain on State Active Duty until age 60. Unless the service member requests earlier separation, separation will occur on that last day of the month the member turns age 60. The Director, State Personnel Programs will advise the appropriate chain of command and the individual service members at least 90 days in advance of separation for mandatory age 60 retirement for the purpose of staff planning and individual retirement actions with CalPERS.

(2) Temporary appointment to a SAD position for personnel past age 60 will require Adjutant General approval and temporary appointment IAW CMVC Section 230. Each temporary appointment will be addressed on a case by case basis and requests will be forwarded to CAJS-SP for processing.

d. Voluntary Separation.

(1) Individuals requesting separation from State Active Duty will complete OTAG Form 900-11 (Request for Separation) and forward it to their immediate supervisor. The supervisor will sign the form and forward it through the chain of command to the Director, State Personnel Programs for final approval. Supervisors desiring to comment on the reason given by the service member for separation may do so by submitting their comments on a separate enclosure.

(2) Voluntary separation requests must be signed by the service member or must contain a statement from the supervisor indicating why the request is not signed and the reason the service member gave for requesting separation.

(3) It is important that the information required by item 5 (current mailing address) of the OTAG Form 900-11 is completed in order to insure that separation documents and unpaid compensation checks are mailed to the correct address.

(4) A final OTAG Form 900-16 (Report of Duty) will be completed signed by the supervisor and forwarded to office of State Personnel Programs. This Report of Duty must be submitted at the time of the individual's request for separation and incorporate the planning of leave in conjunction with lump sum payments and effective dates of departure.

e. Involuntary Separation.

(1) Separation may be initiated by the immediate supervisor or by the Director, State Personnel Programs depending on the reason for separation. Separation of term and temporary service members upon completion of the period established by the appointment order is not considered involuntary and will be accomplished by the Director, State Personnel Programs.

(2) Separation of service members with Term and Temporary Appointment prior to the end of a scheduled term of duty will be initiated by the supervisor using OTAG Form 900-11 (Request for Separation) indicating the reason in item 4.

(3) Separation of service members with Indefinite Appointments due to reduction in staff or funding will be accomplished in accordance with Reduction in Force procedures. The Director, State Personnel Programs will publish a Special State Active Duty Instruction (SADI).

(4) Requests for disciplinary separation will be initiated by the supervisor and forwarded through channels to the Director, State Personnel Programs. The requirements outlined in Chapter 11, Discipline, must be followed when requesting a disciplinary separation.

f. Medical Fitness for Duty Separation.

(1) Service members may exhibit a pattern of frequent absences due to medical problems and/or become seriously ill and unable to perform their duties. In either situation, it is the responsibility of the supervisor to monitor their status and coordinate actions described in this paragraph with the Director, State Personnel Programs. The supervisor must:

(a) Review time and attendance records each month and note patterns of absence based on medical problems. As a general rule, a service member who has 3 or more separate absences in a month, or 7 separate absences in a quarter should be identified to the Director, State Personnel Programs for further evaluation.

(b) Report to the Director, State Personnel Programs any information that is provided by a service member indicating a change in their health and/or doctor's restrictions that may affect their assigned duties.

(2) Requests for fitness determinations and/or separation for medical reasons will be forwarded to the Director, State Personnel Programs. These requests must contain:

(a) A written request from the immediate supervisor.

(b) All available medical documentation regarding current and/or prior medical absences. Medical documentation must specify the nature of the illness (diagnosis) and the prognosis for recovery.

(c) A signed release for medical records from the service member.

(3) The Director, State Personnel Programs will determine if written requests warrants further action or it may be deferred and returned to the submitting supervisor.

(4) The Director, State Personnel Programs may request the evaluation of a medical separation request by the respective (Air or Army) State Surgeon or other military practitioner. In this instance all documentation will be forwarded from The Office of State Personnel to the appropriate medical branch office for coordination. Service members may be separated by The Office of State Personnel concurrent with a recommendation from a State Surgeon. The Director, State Personnel Programs without further review may separate service members who claim medical problems but do not provide requested medical documentation.

(5) A medical board will be convened to process service members with an indefinite appointment based upon the recommendation of a State Surgeon. The board will consist of a State Surgeon, a military physician, and a field grade officer/warrant officer/senior NCO as appropriate, based upon the SAD grade of the individual. The Chief, Medical Services Branch will serve as the board recorder without vote. The Director, State Personnel Programs and a Staff Judge Advocate will serve as advisors to the Board. The board proceedings are limited to review of records. Personal appearance of a service member is not authorized. The recorder will prepare the Board's findings and recommendations and forward them through the Director, State Personnel Programs to the Adjutant General for review and final action.

(6) Service members will be processed for medical reasons when it is clearly indicated that the individual can not return to work. Separation may also be appropriate if the period of illness/injury will be of such duration that it is impractical to return the service member to duty.

5-5. COMMAND ASSIGNMENT POLICY AND PROCEDURE (CAPP)

a. The following assignments require command waivers: State Active Duty service members assigned to brigade, wing, group, battalion, squadron and company commands; headquarters commandants; platoon leaders; command sergeants major, command chief master sergeant or first sergeants positions.

b. The CAPP program goal is to enhance and professionally develop State Active Duty service members. The implementation of CAPP:

(1) Will not be at the expense of a traditional airman or soldier's career progression.

(2) Places qualified State Active Duty service members with critical skills and experience in mobilizing and deploying units.

(3) Affords professional development opportunities to State Active Duty service members normally assigned to the OTAG

c. The Adjutant General is the authority to approve a State Active Duty command assignment outside of OTAG. These assignments should meet the following criteria:

(1) Command and leadership assignments will not exceed three years.

(2) State Active Duty service members may not have had a similar command assignment at the same level regardless of duty status.

(3) The command assignment is voluntary and is to enhance career development. Service members must meet the MOS/AFSC qualifications for the deployable unit's paragraph and line.

(4) Grade inversion is not permitted as a result of a command assignment.

d. The nominating Division will ensure officers taking a command are qualified in accordance with the appropriate Army Regulation or Air Force Instruction. In the case of Army National Guard units, if no qualified officer is available, the Adjutant General may assign officers who are not branch qualified; however, these officers must:

(1) Be approved for branch transfer by a federal recognition board before assuming command.

(2) Complete the military education requirements and meet MOS/AFSC qualifications within 12 months of assignment.

(3) Be a graduate of Command and General Staff College and attend the branch specific Pre-Command Course before assuming command

e. The nominating Division will direct request for exceptions to this policy to the Adjutant General for approval.

CHAPTER 6 RETIREMENT

6-1. GENERAL

- a.* For the purposes of State Active Duty retirement, Term and Indefinite service members shall be enrolled in the California Public Employees Retirement System (CalPERS).
- b.* Retirement eligibility is governed in accordance with the CalPERS regulations and laws.
- c.* Specific information pertaining to retirement ages and annuity amounts can be determined by using the formula provided in the CalPERS retirement pamphlet which is provided to each eligible service member upon appointment.
- d.* An estimate of a retirement allowance can also be obtained by completing the CalPERS Retirement Allowance Estimate Request (PERS-MSD-470) and mailing it to CalPERS, Benefit Application Services Division, P.O. Box 942717, Sacramento CA 94229-2717. Forms may be obtained by contacting the Director, State Personnel Programs.
- e.* Individuals seeking retirement apply to CalPERS using forms provided by CalPERS.

6-2. THE SAVINGS PLUS PROGRAM

The Savings Plus Program is a long-term savings program designed to supplement retirement income. Funds invested in this program are not subject to federal or state income tax at the time of investment but are taxed when savings are withdrawn, normally upon retirement. The program is administered by the Department of Personnel Administration. There are two separate plans within the Savings Plus Program in which members may choose to participate. The Thrift Plan is authorized by Section 401 of the Internal Revenue Code and the Deferred Compensation Plan is authorized by section 457 of the Internal Revenue Code. Information on both plans can be obtained by request from the Director, State Personnel Programs. Other plans may be created by CalPERS and changes in state and federal law.

CHAPTER 7 BENEFITS

7-1. GENERAL

The following state benefits are available to service members with either Term or Indefinite appointments.

7-2. HEALTH BENEFITS

- a.* State Active Duty service members are eligible for health benefits. Service members have 60 days from the appointment date to elect to enroll or not to enroll in a health benefits plan. The effective date of coverage is the first day of the month following receipt of HBD 12 (Health Benefit Plan Enrollment Form) in The Office of State Personnel Programs. Available plans and costs are in the CalPERS Health Program Handbook that is provided to service members upon appointment. Supervisors or other designated individuals at duty sites will explain the various plan coverage and costs to service members. Additional information and assistance may be obtained from the Director, State Personnel Programs.
- b.* Premium Costs. The State contributes a major portion of the premium costs for the State-sponsored health insurance programs. Actual costs vary by plan and by the number of covered dependents. Actual rates for all policies are distributed to supervisors on a continuing basis by CAJS-SP.

7-3. DENTAL BENEFITS

- a.* State Active Duty service members are eligible for Dental care benefits if they are appointed full time and the appointment is for at least one day more than six months. Service members have 60 days from the appointment date to elect to enroll or not to enroll in a dental benefits plan. The effective date of coverage cannot be sooner than the first day of the second month following receipt of the dental plan STD Form 692 (Dental Plan Enrollment Authorization) in The Office of State Personnel Programs. Supervisors or other designated individuals at duty sites will explain the available plans, coverage, and costs to service members. Additional information and assistance may be obtained from the Director, State Personnel Programs.
- b.* Premium Costs. The State contributes a major portion of the premium costs for the State-sponsored dental insurance programs. Actual costs vary by plan and by the number of covered dependents. Actual rates for all policies are distributed to supervisors on a continuing basis by CAJS-SP.
- c.* Dental benefits are controlled by CalPERS.

7-4. VISION BENEFITS

- a.* State Active Duty service members who are eligible for CalPER's membership are also eligible for vision insurance benefits. The premium cost of this benefit is included in the benefit amount provided by the State. The total amount of State-paid premium depends upon individual dependent status and is calculated individually. Supervisors or other designated individuals at duty sites will explain the available plan and coverage to service members. Additional information and assistance may be obtained from the Director, State Personnel Programs.
- b.* CalPERS control vision benefits.

7-5. LIFE INSURANCE BENEFITS

- a.* State Active Duty service members with Term or Indefinite appointment automatically receive department paid life insurance coverage between \$25,000 and \$50,000 in term life insurance depending upon their State Active Duty position and CalPERS regulations.
- b.* All service members can expand their term life insurance coverage in \$5,000 increments. Procedures and forms to accomplish this are found in separate benefit correspondence and can be obtained from the Director, State Personnel Programs.

7-6. DEATH BENEFITS (ON DUTY, LINE OF DUTY)

- a.* State Active Duty service members are provided insurance by CalPERS for death incident to duty related activities. In common military language this is known as death in the "line of duty". The death benefit ranges from \$125,000 to \$160,000 based on the number of dependents and/or other factors. The Director, State Personnel Programs in conjunction with the Staff Judge Advocate will make the determination of status.
- b.* State Active Duty death benefits also include a \$5,000 burial allowance. This amount is provided to offset mortuary, funeral, and cemetery costs. This benefit is a fixed amount regardless of the actual costs (higher or lower).
- c.* Workers compensation laws (labor code) establish state death benefits.
- d.* Application for benefits is similar to standard workers compensation injury actions; supervisors must file initial reports and The Office of State Personnel must forward these reports to the servicing State Compensation Insurance Fund (SCIF) office after a legal review by the Staff Judge Advocate. Additional information, to include police reports, autopsy results, sworn statement, etc. may be required by SCIF during the processing of this claim. Any disputed claims or litigation will be referred to the Staff Judge Advocate.

e. Beneficiary information will be provided by the Director, State Personnel Programs to SCIF; inquiries from immediate family members, next of kin, prior spouse's, etc. will be referred to the claims adjuster at SCIF. The Director, State Personnel Programs may release information to the identified beneficiary.

f. The Director, State Personnel Programs will coordinate with Medical Services Branch for assistance with letters of condolence and/or appointment of a casualty assistance officer (if appropriate), chaplain support and other available resources.

7-7. ADDITIONAL BENEFIT OPTIONS (Generally from CalPERS)

a. Employee Assistance Program (EAP). This program is available to assist State Active Duty service members and their dependents who are experiencing problems related to marriage and/or family relationships, chemical dependency, emotional/psychological stress, legal, financial, childcare or elder care difficulties. There is no cost to the service member. It assists by assessing the nature of their problems and referring them to professional services. Critical incidence counseling is also offered when a service member has had an immediate need for support stemming from a reaction to a life threatening situation related to their duty or a reaction to a fellow service member being killed or seriously injured.

b. Pre-paid legal services. This is a service member-paid program. Enrollment is only authorized at time of initial appointment or during open season announcements. It's voluntary in which the monthly premium is automatically deducted from an enrolled service member's paycheck. The Plan provides 100% paid-in-full coverage when a Plan attorney is used. The Plan pays up to a specified maximum amount when a non-plan attorney is used for covered legal services. The covered services include preparing a will, buying/selling or refinancing a home, adopting a child, filing bankruptcy, serious traffic matters, consumer complaints or representing a child in court. The Plan can also provide defense of civil actions and misdemeanors, and various domestic matters (i. e., annulments, legal separations, divorces, and defense of actions to modify or enforce valid decrees or separation agreements).

c. Long Term Disability. Long term disability insurance program is a service member-paid program. It's voluntary and guarantees income protection against total disability for 65% of the first \$9,230 of the service member's monthly base salary. Enrollment is only authorized at time of initial appointment or during open season announcements. Benefit payments begin after a 180-day waiting period and are coordinated with income from other sources and are continued up to age 65, provided that disability occurs before age 62. If total disability occurs at or after age 62, benefits will be paid according to prescribed time frames, the minimum monthly benefit, or \$100, whichever is greater.

d. Long Term Care is a voluntary program designed for long-term care of CalPERS' members and their dependents. This benefit would be applicable to those persons who may need care for a degenerative disease such as Alzheimer's; or a chronic condition such as Parkinson's disease, and arthritis. Enrollment is only authorized at time of initial appointment or during open season announcements.

e. Deferred Compensation is a benefit, which enable you to save money to increase your financial independence at retirement. It also allows you to defer taxes on the amount you invest until it is withdrawn. Both Federal and State income tax are immediately reduced. This is not a savings account; it is an optional retirement supplement. Eligible service members can participate in two plans authorized by the Internal Revenue Code: Deferred Compensation Plan under Internal Revenue Code (IRC) Section 457; and a Thrift Plan authorized by IRC 401 (k).

f. CalPERS Service Credit Purchase Option. Eligible CalPERS service members with Term or Indefinite Appointment may purchase public service credit for active military duty served before becoming a State of California CalPERS member.

g. CalPERS Member Home Loan Program. Eligible CalPERS service members with Term or Indefinite Appointment may participate in this program which provides security, protection and choice when purchasing – or refinancing – a home.

You can find out more detail about their loan choices, 100 percent loan financing, interest rates and special loan programs at their web site address, www.CalPERS.ca.gov.

CHAPTER 8

DUTY RELATED INJURY/ILLNESS

8-1. GENERAL

For the purposes of this State Active Duty section, service members are covered under the State Compensation Insurance Program (SCIF) for duty related injuries and illnesses.

8-2. BENEFIT

State Active Duty service members receive benefits under the State Workers' Compensation Insurance Fund program. Benefits are provided for duty related injuries and include:

- a.* Payment of all physician, hospital and related medical costs.
- b.* Vocational rehabilitation.
- c.* Permanent disability payments when permanent disability has been established.

8-3. PROCEDURES

- a.* Service member responsibilities. In the event of a duty related illness or injury the service member will:
 - (1) Report any duty-related injury to his/her supervisor immediately but not later than 24 hours after the incident.
 - (2) Obtain medical treatment if necessary and return to duty unless otherwise advised by a physician.
 - (3) Keep supervisor informed of any change in status or condition including a return to duty date, if known.
 - (4) Complete the service member's section of SCIF Form 3301 (Service member's Claim For Workers' Compensation Benefits), and forward to supervisor within 24 hours of illness or injury for completion of the employer portion of the form.
- b.* Supervisor Responsibilities. In the event of a duty-related illness or injury the supervisor will determine the severity of the medical situation and take necessary action considering the following:
 - (1) Service member's wounds, pain, suffering, and urgency for treatment.
 - (2) Service member's physical limitation and transportation requirements to home, physician, or emergency facility (911). If the individual is taken to an emergency facility, the Director, State Personnel Programs must be immediately notified so that emergency notification of next of kin can be accomplished.
 - (3) Complete the employer portion of SCIF Form 3301 (Service member's Claim For Workers' Compensation Benefits), return a copy immediately to service member, and then forward the form to The Office of State Personnel Programs no later than one day after illness or injury occurs. If the service member is unable to complete the service member portion of the SCIF Form, the supervisor must fulfill his/her obligation to submit and alert the Director, State Personnel Programs within 24 hours.
 - (4) Complete SCIF Form 3067 (Employer's Report of Occupational Injury or Illness), and forward to The Office of State Personnel Programs no later than one day after illness or injury occurs.

CHAPTER 9

LEAVE AND HOURS OF DUTY

9-1. GENERAL

a. State Active Duty service members are subject to jurisdiction of California National Guard Manual for Courts-Marshall during the entire period of duty, 24 hours per day and may be required to perform duty at any time. Normally, however, service members are required to report for duty a minimum of 40 hours per week.

b. Normal duty hours for the Military Department are 0800-1630 hours, Monday through Friday.

(1) Directors will have the latitude to modify the duty day by allowing some personnel to begin earlier or stay late to provide the coverage necessary for their Directorate. These modifications will not be less than the general five-day, eight-hours per day work schedule will.

(2) Deputy Adjutants General are authorized to grant temporary adjustments to the workweek to satisfy a specific mission requirement.

(3) Deputy Adjutants General may approve an employee's request for a temporary exception to this policy based only on significant personal hardship, providing the period requested does not adversely impact the mission.

c. Full days of absence from duty other than weekends, holidays or scheduled days off will be charged as ordinary leave, sick leave, military leave, leave without pay, personal holiday, pass (regular or special), as appropriate.

9-2. TYPES OF LEAVE

a. Ordinary Leave

(1) Ordinary Leave is authorized to all personnel on State Active Duty whose appointment exceeds 30 days. Ordinary Leave is earned at the rate of 2.5 days per month. No leave is earned during periods of leave without pay. The computation of leave credit for any fractional part of a month is computed in accordance with applicable Department of Defense military regulations (Table 3-1, AR 630-5, and AFI 36-3003). When individuals on State Active Duty are not performing duty and are away from their duty place for periods of time between duty hours or on weekends or holidays, they are considered as being "on pass".

(2) The use of Ordinary Leave must be approved in advance by appropriate supervisors using OTAG Form 900-14 (Request for Leave). These forms are for local use only and will not be forwarded to the Office of State Personnel. Periods of leave are reported monthly on the Report of Duty form (OTAG 900-16)

(3) Leave taken and leave accrued will be accounted for on a State fiscal year (1 July - 30 June) basis. All ordinary leave accrued in excess of 60 days will be forfeited on 30 June of each year. No waivers are authorized. Ordinary leave, which commences during one fiscal year and is completed in the following fiscal year, will be charged in the fiscal year in which each portion falls. Supervisors are responsible for insuring the use of leave during periods most suitable to their activities, mission and are consistent with member's desires when possible. They must also insure scheduling of leave in such a manner so as to preclude the loss of leave by their subordinates.

(4) Weekends and holidays falling within a period of ordinary leave must be charged as leave.

(5) The day of departure, regardless of the hour, is the first day of leave. If the individual performs duty for half or more of their normal duty hours on the day of departure, the following day will be counted as the first day of leave.

(6) The day of return, regardless of the hour, is the last day of leave unless the individual performed duty for half or more of the normal duty hours, or it is a non-duty day. If duty is performed for half or more of the normal duty hours on the day of return, or if the day of return is a non-duty day, the preceding day will be counted as the last day of leave.

(7) Lump Sum Leave payments may be made to service members with Term or Indefinite appointment separating from SAD with remaining accrued Ordinary Leave at the time of their separation. Service members with temporary appointment are not authorized Lump Sum Leave payment. Lump Sum Leave payments are limited to a lifetime maximum of 60 days and consists of base pay only for each day of accrued leave.

(8) Use of ordinary leave as terminal leave prior to a service member's separation date may be authorized if requested by the member through their supervisor and chain of command and authorized by the Director, State Personnel Programs. Terminal leave must commence so that it is completed on or before the date of mandatory retirement or end of orders.

b. Personal Holiday Pass (PH)

State Active Duty service members with Term or Indefinite appointments are authorized to take one Personal Holiday Pass (PH) consisting of one day off without charge to leave during each fiscal year. Temporary personnel are not authorized a Personal Holiday Pass. The Personal Holiday Pass may not be carried forward from one fiscal year to the next. The use of a Personal Holiday Pass must be approved in advance by appropriate supervisor.

c. Non-Pay Status

State Active Duty service members will be in a non-pay status when on Leave Without Pay (LWOP) or when absent without leave (AWOL). Neither ordinary nor military leave will accrue when in a non-pay status.

(1) Leave Without Pay (LWOP)

(a) Leave without pay will only be granted to State Active Duty personnel under exceptional circumstances. When granted, such leave will be without pay and allowances. Attendance at a service school or performing other active duty (i.e., AAT, ADSW, tours, etc.) after military leave has been totally utilized is considered an "exceptional circumstance".

(b) The use of leave without pay must be approved in advance by the appropriate supervisor and the Director, State Personnel Programs, using OTAG Form 900-14 (Request for Leave). Periods of leave without pay will be reported on OTAG Form 900-16 (Report of Duty).

(2) Absent Without Leave (AWOL)

(a) A service member is considered absent without leave (AWOL) upon:

- (1) Failure to report to duty and without notice to the supervisor.
- (2) Failure to report for duty when a request for leave has been disapproved.
- (3) Failure to return to duty from an approved leave of absence.

(b) Absent without leave will be coded on a full day basis.

(c) Periods of AWOL will be reported on OTAG Form 900-16 (Report of Duty) using Code "AW".

(d) AWOL is an offense that is not tolerated and may subject a member to disciplinary measures. For additional information, refer to Chapter 11, Discipline.

d. Sick Leave

(1) A classification of leave has been developed by the Department for statistical and accounting purposes and for administering the pay of State Active duty personnel during periods of personal illness. It does not provide additional leave but is established to indicate status only. Sick leave may not be used for family illness or injury. Absences required because of family illness or injury will be in an ordinary leave or a leave without pay status.

(2) Sick leave will be coded on a full day basis. The first full day of absence will be considered as the first day of sick leave. The day of return, regardless of the hour, will be considered a day of duty. Sick Leave will be reported on OTAG Form 600-1 (Sick Leave Report), and a copy will accompany the end of month OTAG Form 900-16 (Report of Duty). A statement from a medical doctor, licensed in the State of California, explaining the condition that affects the service member's ability to perform duty or renders the service member unable to perform duty is required for absences over three days, but may be waived by the supervisor for periods up to seven days when the illness or injury can be verified.

(3) When the period of absence due to illness or injury exceeds 30 consecutive days or exceeds 60 days within a 12-month period, a written request for extended sick leave shall be forwarded to the Director, State Personnel Programs. The Director, State Personnel Programs will approve the request or consider convening a medical evaluation board, as appropriate. Refer to paragraph 5-4 f, Medical Fitness for Duty Separation, and the process for Medical Evaluation Boards.

e. Maternity Leave

(1) All service members (with Temporary, Term, or Indefinite Appointment) are eligible for maternity leave.

(2) Service members will continue to perform duties during the prenatal period except when their physical condition incident to pregnancy precludes performing duty. Limited duty tasks may also be designated during this period. Supervisors will obtain confirmation from the member's attending physician regarding inability to perform duty.

(3) Maternity leave will be authorized for 42 calendar days during the postpartum period. Any additional absence requirements for either the care of the member or child will be in a sick leave, ordinary leave or leave without pay status.

f. Military Leave

(1) For the purpose of this section, State Active Duty service members are considered public employees within the meaning of CMVC 395 and related provisions. All service members (with Temporary, Term, or Indefinite Appointment) are eligible for military leave once they meet the statutory one-year requirement described below.

(a) Entitlement to paid military leave begins when an individual has completed one year of continuous service in a State position.

(b) Recognized previous military service may be combined with State service to meet the one-year requirement.

(c) For the purpose of determining eligibility for military leave recognized military service includes full-time service (active duty) during any period of time with the Army, Navy, Air Force, Marine Corps, Coast Guard, to include active duty with reserve components.

(d) Recognized military service also includes prior National Guard service in an Active Guard.

(2) Individuals who qualify for military leave are authorized a maximum of 30 calendar days Military Leave each state fiscal year. With the exception of Inactive Duty Training (IDT), each day of active duty for which federal military pay is received, including weekends and holidays, must be charged to military leave or other leave when military leave is exhausted. When an individual has exhausted all military leave and performs additional active military duty, at the individual's option, ordinary leave or leave without pay will be charged for days when active federal duty is performed. Military leave must be exhausted before ordinary or leave without pay can be charged for military duty, and must be approved in advance by appropriate supervisor using OTAG Form 900-14 (Request for Leave).

(3) Military Leave may be used for the performance of Inactive Duty Training (IDT) during the service member's normal duty hours.

(4) Weekends and holidays falling within a period of military leave must be charged as leave.

(5) State Active Duty service members will receive full State Active Duty pay and allowances while on military leave.

(6) If an individual is not entitled to military leave and performs active military duty, at the individual's option, ordinary leave or leave without pay will be charged for days when active federal duty is performed.

(7) Indefinite military leave is granted to an individual ordered to extended active military duty. If the individual is eligible, the first 30 days of such duty will be in a paid military leave status less any military leave previously used during the fiscal year. In cases where an active duty tour will exceed 180 days (long-term), service members will be separated from SAD and placed on "Military Furlough". The eligible service member will accrue 2.5 days of ordinary leave during the first six months of indefinite military leave.

(8) Under Section 19772, Government Code, "Short-term military leave" means a leave for six months or less and "Long-term military leave" means a leave of over six months. Military furlough status indicates the service member is separated for the purpose of entering on active military duty and is expected to return to his or her State Active Duty position. "Term" and service members with CMVC 167 status may be entitled to reemployment rights.

(9) Upon termination of active military service, State Active Duty personnel on military furlough with reemployment rights may be reinstated to their former or a comparable position of like seniority and pay. The individual must make application for reemployment within 90 days of release from active duty.

(10) Reemployment Rights. The Federal reemployment rights statute (Sections 2024(a) and (b), Title 38, U.S. Code) states that there is a four-year cumulative active duty limitation on assertion of reemployment rights by a returning service member. The four-year cumulative limit applies to active duty performed after 1 August 1961 by a service member while working for the same employer. If the individual's cumulative total of active duty exceeds four years he or she will not be entitled to reemployment rights. If additional service beyond the four years is "imposed pursuant to law" (i.e., the period of duty for an individual involuntarily called to active duty is extended), the individual may still claim reemployment rights. However, this does not apply for a tour extension "at the request and for the convenience of the Federal Government." The following forms of military duty do not count toward the four-year maximum:

- (a) Initial Active Duty for Training (2024(c), Title 32 USC).
- (b) Active Duty for Training (2024(d), Title 32 USC, AT, Schools or ADSW).
- (c) Inactive Duty for Training (2024(d), Title 38 USC Drill, AFTP's).
- (d) Full Time Duty In National Guard (2024(f), Title 32 USC, AGR)
- (e) Call to Active Duty Up to 180 days (6736, Title 10 USC)

g. Pass (Regular and Special)

(1) General.

(a) This section provides information to help approving officials understand regular and special pass periods. These are absences authorized to provide respite from the working environment or for other reasons and not charged to leave.

(b) An approving official is defined as a director, director equivalent or higher.

(2) Regular and Special Pass Information.

(a) Pass Period: A pass period is an authorized absence from duty for a relatively short time.

(1) The period begins at the end of normal working hours on a duty day and ends at the beginning of normal working hours the next duty day.

(2) At the beginning and end of the pass period, the member must be in the local area. The local area is the place from which they regularly commute to work.

(b) Regular Pass: State Active Duty service member are considered to be on a regular pass when in a normal non-duty status, remain in the local area and are subject to recall to the duty site.

(1) A regular pass starts after normal working hours on a given day and stops at the beginning of normal working hours on the next working day.

(2) A regular pass normally begins at the end of working hours on Friday afternoon until the beginning of the normal working hours on the following Monday when non-duty days are Saturday and Sunday.

(3) A regular pass period (non-duty days) for units on non-traditional work schedule (alternative or compressed work schedules) may not exceed the 4-day special pass limitation. The combination of non-duty days and a public holiday may not exceed 4-day special pass limitation. The combination of 3 non-duty days and a public holiday during a compressed work schedule is a regular pass period.

(c) Special Pass: Approving official may award 3 or 4-day special pass for noteworthy duty performance, such as for some type of recognition for extensive service rendered during a state emergency, etc. The special pass is not a service member initiated event, but rather a management-initiated action. Special passes start after normal working hours on a given day. They stop at the beginning of normal working hours on either the 4th day for a 3-day special pass or the 5th day for a 4-day special pass. A 3-day special pass can be Friday through Sunday, Saturday through Monday, or Tuesday through Thursday. A 4-day special pass can be Thursday through Sunday or Saturday through Tuesday. This policy/privilege applies to a normal Monday through Friday workweek.

(d) Regular and Special Pass Guidelines for approving officials:

(1) An approving official may require service members to be able to return to duty within a reasonable time in the event of a mission requirement.

(2) The approving official may revoke regular or special passes at anytime.

(3) Service members must be informed that if the authorized absence exceeds the pass period it will be considered chargeable leave.

(4) Special passes will not be approved in conjunction with leave.

(5) Special passes will not be granted in series.

(6) Service members will be informed that they cannot use regular or special pass periods to extend TDY periods.

(7) A special pass will not be approved if in conjunction with non-duty days exceeding a 4-day special pass limitation.

(8) Service members are authorized a maximum of four days of special pass during any one semi-annual period.

(9) Safe Travel Guidelines. Service members on non-duty status (regular or special pass) should use Operational Risk Management (ORM) principles to assess all hazards and control risks prior to excessive or hazardous travel, especially by automobile.

9-3. REPORTING PROCEDURES

Attendance reporting procedures are outlined in State Active Duty Instructions published whenever required to clarify or expand reporting requirements.

CHAPTER 10 UNEMPLOYMENT INSURANCE

10-1. PURPOSE

This guidance provides administration and management of the Unemployment Insurance (UI) program for State Active Duty service members of the Military Department.

10-2. RESPONSIBILITY

The State Employment Development Department (EDD) has overall responsibility for administering the UI program for all state and private sector service members. Within the Military Department the Director, State Personnel Programs is designated as the administrator of the Department Unemployment Insurance Claims Management Program. It is the responsibility of the Director, State Personnel Programs to insure service members and supervisors are informed of their rights under the California Unemployment Insurance Code and to maintain an internal administrative procedure for monitoring and reviewing UI claims.

10-3. UNEMPLOYMENT BENEFITS AND ELIGIBILITY

a. Unemployment benefits are available to former service members. Service members may be entitled to part or full UI benefits in accordance with the state UI code provided they:

- (1) Are totally unemployed and registered for work with The Employment Development Department.
- (2) Have received a specified minimum amount of wages during the base period.
- (3) Become unemployed through no fault of their own.
- (4) Be physically able to work in their usual occupation, or in other work for which they are reasonably qualified.
- (5) Be available for work, which means ready and willing immediately to accept suitable work in their usual occupation, or in an occupation for which they are reasonably qualified.
- (6) Be actively seeking work on their own behalf.
- (7) Comply with regulations in regard to filing claims.

b. A service member claimant may be disqualified for Unemployment Insurance by EDD under any of the following conditions:

- (1) Voluntary separation.
- (2) Is not legally entitled to work in the United States.
- (3) Was discharged or fired for reasons other than lack of work.
- (4) Performed services as a sports or athletic participant and is expected to do so in the following season.
- (5) Left because of a work dispute.
- (6) Made false statements or withheld information when filing for benefits.
- (7) Is receiving a pension based on prior work.
- (8) Is not able to work, or available for work.
- (9) Has refused employment.
- (10) Is not actively looking for work.

10-4. SERVICE MEMBER CLAIMS PROCEDURES

Claims must be initiated with the local EDD field office by telephone. Adjudication of claims and administration of the unemployment insurance program is the responsibility of the Employment Development Department.

CHAPTER 11 DISCIPLINE

11-1. GENERAL

There are two types of disciplinary actions, adverse administrative action, and military justice. As a general policy, adverse administrative disciplinary actions should be considered before using military justice procedures.

11-2. ADMINISTRATIVE DISCIPLINARY ACTIONS

a. Informal Discipline. Supervisors are responsible for initiating all informal disciplinary actions that include oral and/or written admonitions and warnings.

(1) Informal disciplinary actions are normally admonitions or warnings and usually are the first step in the disciplinary process. An oral admonition is the least severe form of discipline and may be administered by supervisors during scheduled counseling or as on the spot corrective action. When oral admonitions are used, supervisors should clearly advise the service member of the infraction or unauthorized conduct and state what corrective action must be taken. Supervisors may maintain a written record of oral admonitions when they desire and should do so in cases where past admonitions have not been successful or it appears more stringent disciplinary action may be required. Admonitions may also be administered in writing but remain an informal action. Written admonitions are not filed in service members' official personnel files. They must indicate that they are admonitions and not letters of reprimand.

(2) When informal disciplinary action fails to obtain desired results or a service member's action warrants a more severe action than an admonition, the formal discipline procedures indicated below will be used.

b. Formal Discipline. Supervisors are responsible for initiating all formal disciplinary actions, which include written reprimands, suspensions, and terminations.

(1) Written reprimands are applicable to State Active Duty service members. Written reprimands must be coordinated with the Director, State Personnel Programs prior to being issued to the service member.

(2) Suspension without pay is a penalty applicable to State Active Duty service members. Service members are prohibited from working for a specified period of time and their salary is adjusted accordingly. Many of these actions are for one to ten working days, but could be longer if circumstances warrant. Termination should be considered for suspensions in excess of 30 days. Suspensions should be used only when it is necessary to have the service member off the work site. The seriousness of the offense as well as the service member's prior record will be considered in determining the length of the suspension. The Director, State Personnel Programs will be contacted for guidance.

(3) Reduction in State Active Duty pay grade is a penalty applicable to State Active Duty service members. The immediate supervisor through the chain of command to the Director, State Personnel Programs may initiate a Personnel Action Request Form 900-10 with full documentation. No reduction in State Active Duty pay grade will be taken without first obtaining the approval of the respective Deputy Adjutant General.

(4) Administrative termination may be initiated when informal disciplinary actions or formal administrative actions do not accomplish the desired result and processing under the California State Military Justice Code is not being considered. Administrative termination's must be initiated by supervisors, submitted through channels to the Director, State Personnel Programs and, as a minimum, contain the information indicated in paragraph 11-2c below.

(a) Temporary Appointments - The unexecuted portion of temporary SAD orders may be rescinded for administrative or disciplinary reasons. A request for such action will be submitted through command channels to the Director, State Personnel Programs. In coordination with the Staff Judge Advocate, the Director, State Personnel Programs will make a recommendation to the appropriate Deputy Adjutant General, who will make the final decision.

(b) Term Appointments

(1) Term service members with less than six years of SAD with the Military Department will be processed under the procedures of paragraph 11-2c(2) below.

(2) Term service members with six years of State Active Duty with the Military Department are authorized a Disciplinary Action Board under the procedures of paragraph 11-2c(3) below.

(c) Indefinite Appointments - Service members with indefinite appointments are authorized a Disciplinary Action Board under the procedures of paragraph 11-2c(3) below.

c. Procedures for administrative disciplinary actions

(1) In all cases, the following factors should be considered:

(a) Nature of the offense and rule, law or regulation violated.

(b) Time, date, and place of offense.

(c) Witnesses' name(s) and appropriate statements from each.

(d) Information on past like offenses.

(e) The seriousness of the events which form the basis for the termination.

(f) The likelihood that the events will continue to occur.

(g) The adverse effect on the California National Guard.

(h) The individual's potential for further SAD service.

(i) The individual's past performance and record.

(2) Service members with a Term Appointment and less than six years of State Active Duty service with the Military Department:

(a) The Director, State Personnel Programs will review requests for administrative termination with the submission of OTAG Form 900-11 (Request for Separation).

(b) The Director, State Personnel Programs will issue a letter to the individual stating the nature of the offense and advising the individual that they are granted a period of fifteen days in which to respond to the letter and rebut the charges.

(c) Individuals who are being involuntarily terminated may consult counsel and submit written witness statements with their response.

(d) The Director, State Personnel Programs in coordination with the Staff Judge Advocate will make a recommendation to the appropriate Deputy Adjutant General, who will make the final decision.

(e) Service members do not have the right to appear personally to present their rebuttal.

(3) Service members with Indefinite Appointment or term Appointment with more than six years of State Active Duty service with the Military Department.

(a) In addition to the notice and response rights in 11-2c(2) above, these individuals have a right to have their case considered by a Discipline Action Board (DAB). They do not have the right to appear in person to present their rebuttal. Any response to the Board recommendation will be submitted to the respective Deputy Adjutant General. The Adjutant General is the appeal official.

(b) Director, State Personnel Programs may extend the time limit for either response or final action when appropriate.

11-3. Military Justice

a. All military personnel on State Active Duty are considered to be in a duty status seven days a week, 24 hours a day. As such, they are subject to the disciplinary procedures and requirements of the California Military and Veterans Code which has incorporated the Federal Uniform Code of Military Justice (UCMJ) as California's State Military Justice Code (Sections 102 & 103, CMVC). Thus, all State Active Duty personnel, including federally recognized, non-federally recognized, and State Military Reserve members, are subject to UCMJ discipline administered through state jurisdiction while on State Active Duty, regardless of duty or leave status.

b. State Active Duty disciplinary actions will normally be accomplished in accordance with the California National Guard Manual for Courts-martial and Nonjudicial Punishment.

c. Military justice actions are administered by military commanders in coordination with the Staff Judge Advocate

CHAPTER 12

CODE OF ETHICAL STANDARDS

12-1. GENERAL

a. State Active Duty service members are subject to state rules and regulations pertaining to ethical standards, and the United States Joint Ethics Regulation. The following are considered to be inconsistent, incompatible, or in conflict with acceptable conduct:

(1) Providing confidential information to persons to whom issuance of such information has not been authorized, or using confidential information for personal gain or advantage or for the advantage of others.

(2) Soliciting or accepting, directly or indirectly, any money, loan, employment, business, benefit or other thing of value (in addition to salary paid by the State) from anyone from whom it might be inferred as a gift to influence the State service member concerned.

(3) A SAD service member shall not engage in any employment, which prevents a prompt response to any reporting for duty notification.

(4) Providing or using the names of persons from office records for mailing lists that have not been authorized.

(5) Providing or using unit station lists for use in circulation or advertising of articles or services.

(6) Using the prestige or influence of one's office for personal gain or advantage or for the advantage of others.

(7) Using State time, facilities, records, equipment or supplies for personal use or gain.

(8) Receiving or accepting money, gifts or favors for services rendered during duty hours.

(9) Performance of an unofficial act that may later be subject to the individual's control, inspection, review, audit or enforcement in an official State capacity.

b. Any personal knowledge of actions by service members which seem questionable, or which might be interpreted as falling within one of the above categories, should be brought to the attention of the individual's supervisor immediately.

c. Each member appointed to State Active Duty must complete OTAG Form 900-24 (Incompatible Activity Statement) as part of the employment application.

CHAPTER 13

PERFORMANCE EVALUATIONS

13-1. GENERAL

a. This section prescribes policy and procedure for preparing and submitting performance evaluations for State Active Duty service members.

b. Performance evaluations will be prepared annually as of 30 June on each SAD service member by their immediate supervisor using OTAG Form 900-20, (SAD Evaluation of Performance). Evaluations will be prepared by the immediate supervisor, signed by the supervisor and the service member, and forwarded to the second level supervisor (i.e., the reviewer). The second level supervisor will review the evaluation and may either:

(1) Concur with the evaluation, sign the form, forward the original form to The Office of State Personnel Programs and return the remaining copies to the immediate supervisor; or,

(2) Non-concur with the evaluation. In this case, the difference of opinion should be resolved between the two supervisors prior to the second level supervisor signing the form. In the event the difference cannot be resolved, the second level supervisor should indicate his non-concurrence in the narrative section of the form, sign and forward the form to The Office of State Personnel Programs.

c. Immediate supervisors will not render ratings until they have supervised a service member for at least 90 days. If an immediate supervisor has supervised a service member for less than 90 days on 30 June, the 90 days supervision requirement must be met before the evaluation can be made rather than making the evaluation on 1 July. For example, if supervision commenced on 1 May, the rating could not be made until 1 August.

d. Instructions for preparation of the evaluation form are on the reverse side of the form. Evaluating supervisors should carefully consider the service member's performance in each factor prior to making a rating judgement. Supervisors are reminded of the impact their evaluations may have since the scores from the evaluations may be used for promotion purposes, awards, or reduction in force standing.

CHAPTER 14 UNIFORM WEAR

14-1. GENERAL

a. Service members on State Active Duty will wear the military uniform (Army or Air) with the grade insignia prescribed for their current or highest federally recognized rank.

b. Participating service members of the State Military Reserve (SMR) on State Active Duty (SAD) will wear the uniform prescribed in CALARNGR 670-1.

c. All State Active Duty service members will meet the military appearance standards of AR 600-9 (ARNG), AFI 36-2903 and ANGI 40-502 (ANG), and CALARNGR 670-1 (CSMR).

d. Occasions of wearing civilian attire will be kept to a minimum and requires the advance approval of the individual's supervisor.

e. Request for exception to this policy will be submitted through the chain of command to the Director, State Personnel Programs.

CHAPTER 15 REDUCTION IN FORCE (RIF)

15-1. GENERAL

a. Reductions in numbers of State Active Duty (SAD) personnel and reduction in pay grades may be required due to organizational changes and/or budget restrictions.

b. The determination of the number and grade of State Active Duty positions to be eliminated or reduced and the organizational area to be considered will be made by The Adjutant General after staff review and recommendations.

c. Elimination or downgrading of a position does not necessarily mean the removal, separation, or downgrading of the incumbent. All SAD members of like grade will be considered for removal or reduction.

d. Personnel designated to be removed or reduced will be based on the findings of a Reduction in Force (RIF) board designated by the Adjutant General. Individuals at the same grade as that being considered for reduction or abolishment, who have not been appointed under 167 CMVC, will be separated or downgraded prior to considering individuals appointed under 167 CMVC.

15-2. PROCEDURES

- a.* When a determination is made that a RIF is required within an organizational area, the Deputy Adjutants General will identify specific positions for elimination or reduction in pay.
- b.* All incumbent SAD personnel in the SAD grade or grades of the position or positions to be eliminated or reduced will be listed on an OTAG Form 900-29 (RIF Register).
- c.* A RIF Board will be convened for the purpose of reviewing the performance evaluations, achievements, length of service, physical fitness, past record or other such criteria as The Adjutant General deems appropriate in order to determine which service member(s) will be removed or reduced.
- d.* Each board member will complete an OTAG Form 900-30 (RIF Board Raters Score Sheet) for each service member subject to consideration; service members to be removed or reduced will be determined by the lowest composite score established from the combined score of each Board Member.
- e.* The Director, State Personnel Programs will provide the Board with an OTAG Form 900-31 (SAD Information and Evaluation Sheet) on each service member to be considered.
- f.* Only officers occupying a general officer billet may participate as a member on the RIF Board. The Adjutant General will not be a member on the Board, as this position must be available to consider appeals regarding board results or the board process.
- g.* The board will consist of three general officers: the Deputy Adjutant General, Army Division; the Deputy Adjutant General, Air Division; the Deputy Adjutant General, Joint Staff Division. The Adjutant General may designate any other general officer to serve on the board in the absence of any of the above. The most senior general officer present will act as chairperson.
- h.* The Director of State Personnel Programs will function as Recorder for the Board and is responsible for insuring all necessary information and records are available to the Board for each service member being considered.
- i.* After making a determination, the Board will indicate on the RIF Register the service member(s) selected for removal or reduction. All members of the Board will sign the RIF Register confirming their selection.
- j.* The Director, State Personnel Programs is responsible for preparing appropriate notices to personnel affected by a RIF Board's decision.
- k.* The Staff Judge Advocate will review process, findings and recommendations for legal sufficiency prior to the Adjutant General's review.
- l.* Service members selected for removal under the RIF provisions of this regulation may be considered for assignment to other vacant State Active Duty positions on a statewide basis. The removed or reduced service members must be considered qualified or must be able to become qualified for the position within a reasonable period of time. The RIF Board will make determination of qualification.
- m.* Future SAD vacancies will not be filled until former State Active Duty service members, separated because of RIF, have been offered reemployment at their former level and have either been placed or have declined placement/ assignment. If an individual declines a reemployment offer their name will be removed from the reemployment list. The reemployment right remains for one year from date of separation.
- n.* Entitlement to any separation or other termination allowances will be made in accordance with the Department of Defense Pay Manual as of the date of separation.

CHAPTER 16 FRATERNIZATION POLICY

16-1. GENERAL

Army Regulation 600-20 and U.S. Air Force Instruction 36-2009 detail the specific policy and guidance

applicable to service members on State Active Duty (SAD).

CHAPTER 17

COMPLAINT PROCEDURES

17-1. GENERAL

a. State Active Duty service members shall attempt to resolve problems through the State Active Duty chain of supervision and command. Service members who are dissatisfied with the results may use the procedure outlined in this section subject to following limitations:

(1) For service members with Temporary Appointment or Term Appointments with less than six years State Active Duty service, the final decision authority is the Director, State Personnel Programs in coordination with the Staff Judge Advocate. The Adjutant General is the final appeal authority.

(2) For service members with Term Appointments with greater than six years State Active Duty service or members with Indefinite Appointments, the final decision authority is the respective Deputy Adjutant General. The Adjutant General is the final appeal authority.

b. Definitions:

(1) Complaint – A spoken or written dissatisfaction brought to the attention of management. A complaint includes, but is not exclusive of, discrimination based on race, color, religion, gender (to include sexual Harassment), national origin, age, or physical or mental handicap.

(2) Anonymous Complaint – Anonymous complaints should be resolved by the chain of supervision and command at the lowest level possible.

(3) Equal Opportunity (EO) Complaint – Discrimination based on race, color, religion, gender (including sexual harassment), national origin, age, physical handicap, or retaliation. EO complaints are initiated and processed in accordance with this regulation.

(4) Equal Employment Opportunity (EEO) Complaint – See State Civil Service Regulation 690-3.

c. Procedures:

(1) Every effort will be made to find an acceptable solution by informal means at the lowest possible level of supervision. If the service member is not in agreement with the decision reached by discussion, he or she must then file a complaint in writing within 10 calendar days after receiving the informal decision of their immediate supervisor. The OTAG Form 900-26 (SAD Complaint Form) will be used in submitting all complaints.

(2) First Level of Review. The complaint will be presented in writing to the service member's immediate supervisor who shall enter his or her decision and comments in writing and return the form to the service member within 15 calendar days after receiving the complaint. Failure of the service member to take further action within 10 calendar days after receipt of the decision, or within a total of 25 calendar days if no decision is rendered, will constitute a dropping of the complaint. If the complaint is about a matter involving the first level supervisor or is against the first level supervisor the matter will automatically go to the second level of review.

(3) Second Level of Review. If the service member does not agree with his or her supervisor's decision, or if no answer has been received within 15 calendar days, the service member may present the complaint in writing to an intermediate level of supervision. This second level of review should be at the Activity Manager or Directorate level and higher. The supervisor receiving the complaint at this level shall review the complaint, enter his or her decision and comments in writing, and return the form to the service member within 15 calendar days after receiving the complaint. Failure of the service member to take further action within 10 calendar days after receipt of the decision, or within a total of 25 calendar days if no decision is rendered, will constitute a dropping of the complaint.

(4) Final Review. If the service member does not agree with the decision reached at the second level, or if no answer has been received within 15 calendar days, he or she may present the complaint in writing through the respective Deputy Adjutant General for review and decision, subject to the limitations in paragraph 17-1a (1) and (2).

(5) For those subject to the provisions of paragraph 17-1a(2) above the Director, State Personnel Programs shall forward the complaint to the respective Deputy Adjutant General for final review and decision.

(6) Appeal. The Adjutant General will rule on all complaint appeals submitted through the Director, State Personnel Programs.

(7) The Director, State Personnel Programs may extend the time limits specified above in writing.

CHAPTER 18 PHYSICAL FITNESS STANDARDS

18-1. GENERAL

State Active Duty members are to meet military physical fitness and medical standards established for their under-lying active militia component and will accomplish the component's annual physical fitness test by the end of each calendar year. The respective DAG or TAG in compliance with military service component rules will address failures. Service members on the retired list and on State Active Duty are exempt from the above physical fitness standards.

CHAPTER 19 STATUS OF SAD MEMBERS DURING STATE EMERGENCIES

19-1. GENERAL

a. Service members who are on State Active Duty pursuant to Section 142 of the California Military and Veterans Code (CMVC), who are ordered to perform State emergency field duties with their military unit and who perform such duties in their military Manning Document Assignment (i.e., TOE, TDA, UMD), will receive pay for such duty at the rate of their federally recognized grade, to include flight pay and crew pay, if appropriate.

b. Service members on duty pursuant to Section 142 of the California Military and Veterans Code (CMVC), who are ordered to perform emergency field duties pursuant to CMVC 143/146 as a representative of the Office of the Adjutant General, and where such duties are outside the normal duties and responsibilities of their SAD assignment and commensurate with their federally recognized grade, will receive pay for such duty at the rate of their federally recognized grade or at the Cooperative Agreement Wildfire Pay rate, as appropriate. Based upon the nature of their emergency duty assignment, and the pay rate applicable, the member could be eligible for flight pay and hazardous duty pay.

c. In all cases where pay is due an individual at his or her federal grade, they will receive their regular State Active Duty paycheck and will receive differential pay by emergency payroll.

d. Members performing emergency duties under any circumstances other than a. or b. above will continue to receive the pay of their regular State Active Duty (SAD) assignment.

CHAPTER 20 TRAINING POLICIES AND PROCEDURES

20-1. GENERAL

a. It is the goal of the Military Department to carry out its training responsibilities effectively and economically. This includes any duty-related training.

b. This goal can best be accomplished by developing service member skills and knowledge needed to perform essential duties. The development of the necessary skills and knowledge will be accomplished and enhanced through a comprehensive program of service member training and development.

c. To reach this goal, the Military Department policy is to:

(1) Review applicable government code sections as a guide and appropriate application.

(2) Provide adequate training for service members to enable them to perform work assignments satisfactorily.

(3) Provide training and development opportunities that are cost effective.

(4) Assure that supervisors are trained to accomplish on the job training.

(5) Provide for service member career development and upward mobility within State service.

20-2. CATEGORIES OF TRAINING

a. Job Required Training. Training that is designed to assure adequate performance in a service member's current assignment. Job-required training includes:

(1) Orientation training to acquaint all new service members with State service, departmental organization, and State departmental personnel practices and service member benefits:

(2) Training necessary to newly assigned service members, including supervisors and managers, to acquire an acceptable level of competency in their assignment;

(3) Continuing and refresher training to maintain effective operation of departmental programs;

(4) Training mandated by law or other State authority, including safety training.

b. Job Related Training. Training that increases a service member's job proficiency. Job related training includes training that:

(1) Enables a service member to improve his/her job performance above the acceptable level of competency established for the specific job assignment;

(2) Prepares the service member for assuming increased responsibilities in his/her current assignment.

c. Upward Mobility Training - Training that is designed to assist both a service member and the Department to achieve an upward mobility goal of mutual interest.

d. Career Related Training - Training that assists the service member in developing his/her career potential. This training should not relate to the achievement of a departmental upward mobility goal. It is designed to help provide the service member with an opportunity for self-development while also being worthwhile toward achieving a department's or the State's mission. This training does not have to be related to the service member's current job.

20-3. PRIORITY OF RESOURCES

a. Resources for meeting departmental training needs shall be allocated in the following priority order for both in-service and out-service training:

(1) Duty-Required Training

(2) Duty-Related Training

(3) Upward Mobility Training

(4) Career-Related Training

b. State training activities are defined as either in-service or out-service training.

- (1) In-service training is sponsored, administered, or contracted for by the State for its service members. The State maintains a high degree of control over the course content of in-service training.
- (2) Out-service training may be provided by a non-State agency.

20-4. RESPONSIBILITIES

- a. Commanders and Directors are responsible for both on the job and formal training of all service members in subjects necessary to carrying out assigned tasks in the most efficient manner. Commanders and Directors will summarize training needs of service members annually when completing OTAG Form 900-20 (SAD Evaluation of Performance).
- b. Director, State Personnel Programs will prepare cost and operational data, annual reports and submit recommendations for the Department Training Plan. The State Personnel Programs office has the overall staff responsibility for program coordination and will assist management in planning and developing training materials, providing training information, including announcements and bulletins of training availability, overall guidance, evaluation and other staff duties.
- c. Service members shall participate in training required by the department. In addition, it is up to each service member to seek training opportunities to improve duty performance.

20-5. PROCEDURES

- a. Yearly Training Plan
 - (1) Commanders and Directors will summarize the training needs of service members annually. An OTAG Form 900-33 (Yearly Training Plan) will be completed by each Activity/Directorate and submitted through appropriate DAG to State Personnel Programs annually by 1 May.
 - (2) Commanders and Directors who can reasonably predict turnover based on previous experience should identify the appropriate mandated and job-required training for future service members. OTAG Form 900-20 (State Active Duty Evaluation of Performance) may be used to assess service member training needs.
 - (3) The Director, State Personnel Programs will review activity training plans, develop the Military Department's yearly training plan, and submit to The Adjutant General for approval. The approved Yearly Training Plan will be used to determine funding requirements and to establish priorities for training to be accomplished during the fiscal year.
- b. Service member training requests (OTAG Form 900-34) will be submitted through the appropriate Deputy Adjutant General to determine if the requested training is appropriate and justified for the service member's current duty assignment, and then to the Director, State Personnel Programs for processing. The Director, State Personnel Programs will:
 - (1) Insure that funds are available to support the requested training.
 - (2) Forward a copy of approved request to service member's supervisor.

20-6. REPORTING REQUIREMENTS

- a. The State of California, Department of Personnel Administration has established an annual training report (Fiscal Year) requirement.
- b. State Personnel Programs will maintain training records on all requests. It will be the responsibility of the commanders and directors to provide State Personnel Programs with the training information for the following types of training:
 - (1) Training that is conducted in-house at no cost to the department.
 - (2) Training that is sponsored by other State or Federal agencies at no cost to the department.
 - (3) Any other training of State service members that was not processed through State Personnel Programs.

c. Annual Training Reports (OTAG Form 900-35) will be used by commanders and directors to report the above training and must be submitted to State Personnel Programs not later than 15 September annually.

APPENDIX A - FORMS LIST ORDER FORM

<u>Order?</u>	<u>List</u>	<u>DESCRIPTION</u>
—	A-1	HBD-12 (Health Benefit Plan Enrollment Form)
—	A-2	HBD012A (Declaration of Health Coverage)
<u>R</u>	A-3	I-9 (Employment Eligibility Verification)
<u>R</u>	A-4	OTAG Form 600-1 (Sick Leave Report)
<u>R</u>	A-5	OTAG Form 900-7 (Emergency Information Form)
<u>R</u>	A-6	OTAG Form 900-8 (State Active Duty Appointment Application)
<u>R</u>	A-7	OTAG Form 900-10 (State Active Duty Personnel Action Request)
<u>R</u>	A-8	OTAG Form 900-11 (State Active Duty Separation Request)
<u>R</u>	A-9	OTAG Form 900-12 (Certificate of Dependents)
<u>R</u>	A-10	OTAG Form 900-13 (State Active Duty Position Request)
<u>R</u>	A-11	OTAG Form 900-13a (Position Description)
<u>R</u>	A-12	OTAG Form 900-14 (Request for Leave)
<u>R</u>	A-13	OTAG Form 900-15 (Statement of Service)
<u>R*</u>	A-14	OTAG Form 900-16 (Report of Duty-State Active Duty Personnel)
<u>R</u>	A-15	OTAG Form 900-17 (Federal Privacy Act Information Statement)
<u>R</u>	A-16	OTAG Form 900-20 (SAD Evaluation of Performance)
<u>R</u>	A-17	OTAG Form 900-24 (Incompatible Activities Statement)
<u>R</u>	A-18	OTAG Form 900-26 (SAD Complaint Form)
<u>R</u>	A-19	OTAG Form 900-27 (Statement of State Active Duty Status)
<u>R</u>	A-20	OTAG Form 900-27a (Statement of Understanding, SAD Special Programs)
<u>R</u>	A-21	OTAG Form 900-28 (Service Member Clearance Form)
<u>R</u>	A-22	OTAG Form 900-29 (SAD Reduction in Force (RIF) Register)
<u>R</u>	A-23	OTAG Form 900-30 (SAD RIF Board Evaluators Score Sheet)
<u>R</u>	A-24	OTAG Form 900-31 (SAD Information and Evaluation)
<u>R</u>	A-25	OTAG Form 900-33 (Yearly Training Plan)
<u>R</u>	A-26	OTAG Form 900-34 (Training Request)
<u>R</u>	A-27	OTAG Form 900-35 (Annual Training Report)
<u>R</u>	A-28	OTAG Form 900-36 (Task Listing)
—	A-29	PERS-MEM-42 (Acknowledgment of Receipt of Retirement Information)
—	A-30	SCIF Form 3067 (Employer's Report of Occupational Injury/Illness)
—	A-31	SCIF Form 3301 (Service Members Claim for Workers Compensation Benefits)
<u>R*</u>	A-32	DD Form 2807-1 (Report of Medical History)
<u>R</u>	A-33	SPB 1070 (State Service Member Race/Ethnicity Questionnaire)
<u>R</u>	A-34	STD Form 243 (Designation of Person Authorized to Receive Warrants)
<u>R</u>	A-35	STD Form 677 (Request for Non-disclosure of Employees Home Address)
—	A-36	STD Form 686 (Employee Action Request)
—	A-37	STD Form 687 ((Separation/Disposition of PERS Contributions)
<u>R</u>	A-38	STD Form 689 (Oath of Allegiance)
—	A-39	STD Form 692 (Dental Plan Enrollment Authorization)
<u>R</u>	A-40	STD Form 951 (PST Retirement Plan Benefit Payment Application)
—	A-41	STD Form 699 (Direct Deposit Enrollment Authorization)
<u>R</u>	A-42	DPA 025 (Affidavit of Eligibility)
—	A-43	STD Form 241 (Beneficiary Designation)
<u>R</u>	A-44	HBD-35 (Affidavit of Eligibility for Economically Dependent Child)
<u>R</u>	A-45	PERS HBSD 1965 (Affidavit of Marriage)

R Indicates that the form is reproducible at local area. Blank lines allow you to order the special forms from the State Personnel Programs Office.

* NOTE: An asterisk indicates that the form has been updated for the year 2002.

APPENDIX B – KEY STAFF POSITIONS (STATE AND FEDERAL)

1. OFFICE OF THE ADJUTANT GENERAL

- a.* Chief of Staff, California National Guard
- b.* Executive Officer
- c.* Executive Services Officer
- d.* State Sergeant Major
- e.* Director, Policy and Liaison
- f.* Director, Public Affairs
- g.* Director, Media Services
- h.* General Counsel, SJA
- i.* Inspector General
- j.* State Chaplain
- k.* Secretary, General Staff
- l.* Aide-de-Camp

2. JOINT STAFF DIVISION

- a.* Deputy Adjutant General, Joint Staff
- b.* Chief of Staff, Joint Staff
- c.* Executive Officer
- d.* Chief Information Officer
- e.* Director, State Personnel Programs
- f.* Director, State Comptroller
- g.* Director, Human Resources
- h.* Director, Administration
- i.* Director, Information Management
- j.* Director, Plans, Operations and Security
- k.* Director, Internal Controls
- l.* Director, State Safety Programs
- m.* Executive Officer, Federal Youth Programs

3. ARMY DIVISION

- a.* Deputy Adjutant General, Army
- b.* Chief of Staff, Army
- c.* Executive Officer
- d.* Command Chief Warrant Officer
- e.* Director, Military Personnel
- f.* Director, Logistics
- g.* Director, Organization and Training
- h.* Director, Army Aviation and Safety
- i.* Director, Installations and Facilities
- j.* Director, Environmental Programs
- k.* Director, Surface Maintenance
- l.* Senior Army Advisor
- m.* Commander, Camp Roberts
- n.* Commander, Camp San Luis Obispo
- o.* Commander, Los Alamitos, JFTB

4. AIR DIVISION

- a.* Deputy Adjutant General, Air
- b.* Chief of Staff, Air
- c.* Executive Officer
- d.* Director, Operations
- e.* Director, Logistics

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California Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN
ENROLLMENT FORM
PERS-HBD-12 (Rev. 03/01)

**DO NOT SEND MEDICAL
CLAIMS TO THIS ADDRESS**

CalPERS USE ONLY—DOCUMENT REFERENCE NUMBER

PLEASE TYPE

1. TYPE OF ACTION (Check One) <input type="checkbox"/> a. NEW enrollment <input type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage	2. SOCIAL SECURITY NUMBER — —	ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH			Family Relationship SELF	CODE
	3. SPOUSE'S SOCIAL SECURITY NUMBER — —		17. BASIC PLAN (FIRST) (MI) (LAST)	Mo.	Day	Yr.		
4A. Name (FIRST) (MI) (LAST) Mailing Address City, State, ZIP								
4B. RESIDENCE ZIP CODE (If different from 4A)								
5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)	6. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	7. MARRIED <input type="checkbox"/> Yes <input type="checkbox"/> No						
8. PLAN CODE	9. NAME OF HEALTH PLAN							
10. GROSS PREMIUM \$	11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP							
12. PRIOR PLAN CODE	13. PRIOR HEALTH PLAN							
14. Permitting Event Code	15. Permitting Event Date Mo. Day Year	16. EFFECTIVE DATE Mo. Day Year 01	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo. Day Yr.			Relation-ship	C O D E

19. CHECK ONE

- ☐ I **DO NOT** wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to **ENROLL IN (OR CHANGE TO)** a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to **CANCEL** the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy)

21. DATE SIGNED
Mo. Day Year

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE	23. Type of action (Check One) <input type="checkbox"/> New <input type="checkbox"/> Cancel <input type="checkbox"/> Change	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
28. AGENCY NAME (or Retirement System)	29. PAYROLL OFFICE CODE		30. AGENCY CODE	31. UNIT CODE	

32. I hereby certify under penalty of perjury as follows: SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in
employing office
Mo. Day Yr.

34. PHONE NUMBER
()

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825-22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, California Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

35. REMARKS

_____ of _____ Forms

BLUE—EMPLOYEE



Declaration of Health Coverage
HB-12A (01/01/98)

California Public Employees' Retirement System
Health Benefit Services Division
P.O. Box 942714; Sacramento, CA 94229-2714
(800) 237-3345

(INSTRUCTIONS ON REVERSE)

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME (FIRST) (MIDDLE) (LAST)
PART A <input type="checkbox"/> I elect to enroll myself and all eligible dependents.	
PART B-1 <input type="checkbox"/> I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage.
PART B-2 <input type="checkbox"/> I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.	If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.
PART C-1 <input type="checkbox"/> I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
PART C-2 2. <input type="checkbox"/> I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependent, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependent, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

Member's Signature
HB-12A (01/98)

Date Signed
Original: Employee's Personnel File

Health Benefits Officer's Signature
Copy: Employee

INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

<i>Please contact your Health Benefits Officer if you have any questions regarding the HB-12A</i>	
Employee Information	Complete with the appropriate employee information.
PART A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
PART B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage.
PART B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
PART C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
PART C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents; or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not enrolled in a CalPERS-sponsored health plan on the date you separate employment, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are not enrolled on your CalPERS-sponsored health plan at that time, they will not be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1 - Employee. All employees, citizens noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record:** 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/ reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

- and • If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:
- examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C),
 - record the document title, document number and expiration date (if any) in Block C, and
 - complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the INS Handbook for Employers, (Form M-274). You may obtain the handbook at your local INS office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 U.S.C. 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Naturalization Service, the Department of Labor, and the Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood, and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to both the Immigration and Naturalization Service, 425 I Street, N.W., Room 5304, Washington, D. C. 20536; and the Office of Management and Budget, Paperwork Reduction Project, OMB No. 1115-0136, Washington, D.C. 20503.

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136
Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE.** It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.


Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.		I attest, under penalty of perjury, that I am (check one of the following): A citizen or national of the United States A Lawful Permanent Resident (Alien # A _____) An alien authorized to work until ____/____/____ (Alien # or Admission # _____)	
Employee's Signature			Date (month/day/year)

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): ____/____/____		____/____/____		____/____/____
Document #: _____				
Expiration Date (if any): ____/____/____				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) ____/____/____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	
		Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.	
Document	Title: _____ Document #: _____ Expiration Date (if any): ____/____/____
I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.	
Signature of Employer or Authorized Representative	Date (month/day/year)

LISTS OF ACCEPTABLE DOCUMENTS

LIST A		LIST B		LIST C
Documents that Establish Both Identity and Employment Eligibility	OR	Documents that Establish Identity	AND	Documents that Establish Employment Eligibility
1. U.S. Passport (unexpired or expired)		1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		1. U.S. social security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>)
2. Certificate of U.S. Citizenship (<i>INS Form N-560 or N-561</i>)		2. ID card issued by federal, state, or local government agencies or entities provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (<i>Form FS-545 or Form DS-1350</i>)
3. Certificate of Naturalization (<i>INS Form N-550 or N-570</i>)		3. School ID card with a photograph		3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Unexpired foreign passport, with <i>I-551 stamp</i> or attached <i>INS Form I-94</i> indicating unexpired employment authorization		4. Voter's registration card		4. Native American tribal document
5. Alien Registration Receipt Card with photograph (<i>INS Form I-151 or I-551</i>)		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (<i>INS Form I-197</i>)
6. Unexpired Temporary Resident Card (<i>INS Form I-688</i>)		6. Military dependent's ID card		6. ID Card for use of Resident Citizen in the United States (<i>INS Form I-179</i>)
7. Unexpired Employment Authorization Card (<i>INS Form I-688A</i>)		7. U.S. Coast Guard Merchant Mariner Card		7. Unexpired employment authorization document issued by the INS (<i>other than those listed under List A</i>)
8. Unexpired Reentry Permit (<i>INS Form I-327</i>)		8. Native American tribal document		
9. Unexpired Refugee Travel Document (<i>INS Form I-571</i>)		9. Driver's license issued by a Canadian government authority		
10. Unexpired Employment Authorization Document issued by the INS which contains a photograph (<i>INS Form I-688B</i>)		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Sick Leave Report

1. NAME: _____ SSN: _____

2. EMPLOYING ACTIVITY: _____

3. SUPERVISOR STATEMENT:

The above named individual was absent from work for the reason indicated on the following dates:

Dates:

_____ Medical/Dental Appointment

_____ Sick in Hospital

_____ Sick at Home

_____ Other (explain)

Nature of illness or Injury:

Supervisor's Signature

4. DOCTOR'S STATEMENT:

I examined, treated or prescribed for the above named patient on these dates: _____

Date returned to work or estimated date of return: _____

Nature of Illness or Injury:

Doctor's Signature

Emergency Information Form

NAME: _____ SSN: _____ DOB: ____/____/____
First Middle Last Month Day Year

HOME ADDRESS: _____
No & Street

City ZIP PHONE: (____) _____
Area Code

Married _____ Single _____ Spouse's Name: _____

PERSON(S) TO BE NOTIFIED IN THE EVENT OF AN EMERGENCY:

_____ Name	_____ No & Street	_____ Phone
	_____ City ZIP	
_____ Name	_____ No & Street	_____ Phone
	_____ City ZIP	
_____ Name	_____ No & Street	_____ Phone
	_____ City ZIP	

I certify the above information is correct and understand that I must submit a revised form to the Directorate of State Personnel Programs when any of the above information changes.

Signature

Date

CALIFORNIA NATIONAL GUARD SAD APPOINTMENT APPLICATION

[illegible]

CALIFORNIA NATIONAL GUARD
SAD APPOINTMENT APPLICATION
(CONTINUED)

12. EMPLOYMENT HISTORY (Show last 10 years)			
a.	FROM:	TO:	POSITION TITLE: SALARY:
EMPLOYERS NAME & ADDRESS			
DESCRIPTION OF DUTIES:			
REASON FOR LEAVING:			
b.	FROM:	TO:	POSITION TITLE: SALARY:
EMPLOYERS NAME & ADDRESS			
DESCRIPTION OF DUTIES:			
REASON FOR LEAVING:			
c.	FROM:	TO:	POSITION TITLE: SALARY:
EMPLOYERS NAME & ADDRESS			
DESCRIPTION OF DUTIES:			
REASON FOR LEAVING:			
d.	FROM:	TO:	POSITION TITLE: SALARY:
EMPLOYERS NAME & ADDRESS			
DESCRIPTION OF DUTIES:			
REASON FOR LEAVING:			
e.	FROM:	TO:	POSITION TITLE: SALARY:
EMPLOYERS NAME & ADDRESS			
DESCRIPTION OF DUTIES:			
REASON FOR LEAVING:			
f.	FROM:	TO:	POSITION TITLE: SALARY:
EMPLOYERS NAME & ADDRESS			
DESCRIPTION OF DUTIES:			
REASON FOR LEAVING:			
I certify all of the above information to be true and correct.			
SIGNATURE:			

State Active Duty Personnel Action Request

1. Action Requested: ☐ Appointment ☐ Reassignment ☐ Promotion
☐ Pay Rate Change ☐ Extension ☐ Other

2. Requesting Activity: _____

3. Position:

a. TO: _____ SAD Grade _____ Position Number _____
Title

b. FROM: _____ SAD Grade _____ Position Number _____
(Not required for new appointments) Title

2. Individual's Name: _____ MI
Last First

SSN: _____ Federally Recognized
Military Grade: _____

Military Unit: _____

5. a. Proposed Effective Date: _____ b. Period: _____
Status: Temporary Term Indefinite
(Circle One)

6. Vice: _____

7. Requesting Official: _____

8. Recommend Approval: _____

9. Position Verified: _____ Date: _____
State Personnel Programs Office Representative

10. Funds Verified: _____ Date: _____
Index: _____ Military Department Comptroller Representative

11. Approved: _____ Date: _____
AG or Representative

Remarks:
PEBD: _____
Duty Location: _____
Flag Check: _____
Phys Review: _____

State Active Duty Separation Request

1. Name: _____ SSN: _____
2. Position Title/SAD Grade/Number: _____
3. Employing Activity: _____
4. Reason for Separation: _____

☐ **Service Member Initiated Resignation**

I resign from my position on State Active Duty effective COB _____ for the following reason(s):

Signature of Employee

Date:

Signature of Supervisor

Date:

☐ **Supervisor Initiated Separation**

I request the above named individual be separated from his/her State Active Duty position
Effective COB _____ for the following reason(s):

Signature of Supervisor

Date:

Signature of 2nd Line Supervisor

Date:

Approved: _____

AG/Representative

Date: _____

5. Address to which separation documents and warrants for unpaid compensation should be mailed:

Certificate of Dependents

Last Name	First Name	Initial	Grade	SSN
-----------	------------	---------	-------	-----

1. ☐ I have no dependents.

2. ☐ I certify the following named persons are my dependents for the purpose of receiving basic allowance for quarters:

a. **Lawful Spouse:**

NAME

ADDRESS

DATE OF MARRIAGE

b. **Children:**

NAME

ADDRESS

AGE

*STATUS

3. I further certify that my dependents are/are not occupying public (State or Federal) quarters without charge or if occupying such quarters the occupancy charge is \$ _____ per month.

4. I will immediately notify the Directorate of State Personnel Programs of any changes in the status of my dependents.

Signature

date

*Legitimate
Step Child
Adopted

State Active Duty Position Request

1. Division/Activity: _____
2. Branch/Section: _____
3. Action Requested: ☐ New Position ☐ Retitle Position ☐ Reclass Position
4. Present Title/Grade: _____
Proposed Title/Grade: _____
5. Justification for Action: (Also attach position description and task listing OTAG Form 900-13a and 900-36)

6. Requesting Official: _____ Date: _____
7. Division/Activity Approval: _____ Date: _____
8. State Personnel Branch Concurrence: _____ Date: _____
9. Fund Verification: _____ Date: _____
10. AG or Designated Representative Approval: _____ Date: _____
11. OTAG Position Number Assigned: _____ Effective Date: _____

Position Description

Position Number: _____ Date: _____
Position Title: _____ Pay Grade: _____
Location: _____

The following duties, responsibilities and qualification requirements constitute minimum requirements for this position:

a. SUPERVISORY CONTROLS:

b. DUTIES AND RESPONSIBILITIES:

c. QUALIFICATIONS:

Request for Leave

TO: _____

(Appropriate Supervisor)

Requests that I be granted leave from SAD as follows (check appropriate box):

☐ ORDINARY LEAVE

☐ LEAVE W/O PAY (Indicate Reason Below)

☐ MILITARY LEAVE

☐ HOLIDAY CREDIT (Indicate Holiday Below)

REASON (If required):

PERIOD: _____ 20 THRU: _____ 20 INCLUSIVE

SIGNATURE

TYPED NAME AND GRADE OF
INDIVIDUAL REQUESTING LEAVE

APPROVED:

SIGNATURE OF INDIVIDUAL
APPROVING REQUEST FOR LEAVE

DATE

Statement of Service

Date _____

I, _____
(Name) (Grade) (Social Security No.)

hereby certify that I am entitled to service credit in accordance with paragraph 10101, Military Pay and Allowance Entitlements Manual (See reverse), for service indicated below. I have attached documents to verify all periods of service other than California National Guard.

Service or component	From			To		
	Day	Month	Year	Day	Month	Year
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

AUTHENTICATION BY
STATE PERSONNEL OFFICE

SIGNATURE _____

PART ONE BASIC AND SPECIAL PAY CHAPTER 1

SERVICE CREDITABLE

10101. Service Creditable

Basic pay varies with the number of years' service a member has credited. In computing cumulative years of service for this purpose, members are credited full-time service as follows:

- a. Organizations in General. Active or inactive service as an officer, warrant officer, or enlisted member in any of the following:

- Air Force Reserve
- Air Force of the United States (without specification of component)
- Air National Guard
- Air National Guard of the United States
- Army of the United States (without specification of component)
- Army National Guard
- Army National Guard of the United States
- Army Reserve
- Coast Guard Reserve
- Marine Corps Reserve
- National Guard
- National Guard of the United States
- National Oceanic and Atmospheric Administration (see c. below)
- Naval Reserve
- Nurse Corps of the Public Health Service
- Nurse Corps Reserve of the Public Health Service
- Public Health Service
- Regular Air Force
- Regular Army
- Regular Army Reserve
- Regular Coast Guard
- Regular Marine Corps
- Regular Navy
- Reserve Corps of the Public Health Service

- b. Nurse Service Before 16 Apr 1947. Creditable periods are those during which members held appointments as a nurse, Reserve nurse, or commissioned officer in the Army Nurse Corps or the Navy Nurse Corps, or the Reserve components thereof, as they existed before 16 Apr 1947.

- c. National Oceanic and Atmospheric Administration (NOAA). Periods during which a member was an officer, deck officer, or junior engineer in the NOAA (includes periods served in the former corps of the Environmental Science Services Administration or the Coast and Geodetic Survey) is creditable service.

- d. Service Counted on 10 Jan 1962. All service is creditable which, under any law in effect on 10 Jan 1962, was creditable in computing basic pay.

- e. Service on Retired List or as Member of Fleet Reserve or Fleet Marine Corps Reserve. Creditable periods are those while on a temporary disability retired list, honorary retired list, or retired list of any uniformed service; and periods while entitled to retired pay, retirement pay, or retainer pay from any uniformed service or the Veterans Administration as a member of the Fleet Reserve or Fleet Marine Corps Reserve.

- f. Women's Army Auxiliary Corps. Effective 7 Aug 1959, active service during the period 14 May 1942 through 29 Sep 1943 as a member of the Women's Army Auxiliary Corps (WAAC) may be counted if active military service is performed after 29 Sep 1943.

- g. Army and Air Force Officers Restored To Duty Under Act of 29 Jun 1948. The period between date of removal and date of restoration of an Army or Air Force officer restored to the active list under the Army and Air Force Vitalization and Retirement Equalization Act of 1948 is creditable.

- h. Retention for Medical Care After Expiration of Term of Service. Any period on and after 12 Dec 1941 when an enlisted member of an Armed Force is retained in service, after expiration of his or her term of service, for medical treatment or hospitalization for disease or injury incident to service and not due to his or her misconduct is creditable.

- i. Service Before Attainment of Statutory Age for Enlistment. Any service which is otherwise creditable may be counted even if the service was performed before a member attained the statutory age for enlistment. Such service

may not be counted if it is determined to be fraudulent and is voided for that reason.

j. Temporary Member of Coast Guard Reserve. Active service performed as a temporary member of the Coast Guard Reserve is creditable.

- k. Army of the United States Commissions—World War II. Appointments made on and after 7 Dec 1941 in the Army of the United States, without component, under the Joint Resolution of 22 Sep 1941, are considered to have continued in effect through 31 Mar 1953 unless terminated before that date by administrative action or specific law. The period from the date of separation through 31 Mar 1953 may be credited for officers who:

- (1) Did not have Reserve or National Guard status,
- (2) Did not accept a Reserve commission, and
- (3) Were separated on or before 31 Mar 1953 without vacating their AUS status.

- l. Warrant Officer Appointment—World War II. For a temporary appointment as a warrant officer under section 3 of the Act of 21 Aug 1941, the period from separation from active duty through 1 Apr 1953 is creditable unless the appointment was expressly terminated earlier.

- m. Flight Officer Appointment—World War II. For an appointment as a flight officer under the Flight Officer Act of 8 Jul 1942, the period from separation from active duty through 27 Oct 1952 is creditable unless the appointment was expressly terminated earlier.
- n. Service Terminated by Desertion or Dishonorable Discharge. Service in an enlistment terminated by desertion or dishonorable discharge is creditable unless the enlistment was fraudulent and was voided for that reason.

- o. Women's Army Corps. Appointments in the Women's Army Corps in the Army of the United States, without component, if not previously terminated, were terminated on 31 Mar 1953. Such service is creditable for basic pay purposes.

- p. Service as Cadet or Midshipman. Cadet or midshipman service is creditable in computing basic pay of enlisted members. For officers, see table 1-1-1.

- q. Detail to Agencies Such as the Agency for International Development (AID), Department

of State, Service with certain other agencies under agreement, as that between the Department of Defense and AID is creditable.

- r. Reserve Officers' Training Corps. Service as a member of the Army, Navy, or Air Force Reserve Officers' Training Corps is creditable service as follows:

- (1) Before 14 Oct 1964. Any member who had concurrent Reserve status.
- (2) After 13 Oct 1964. An enlisted member who had concurrent Reserve status.
- s. Aviation Midshipman. Service in the aviation midshipman program, Act of 13 Aug 1946, chapter 962, 60 Stat 1057, is creditable service for basic pay purposes effective on and after 26 Dec 1974.

- t. Delayed Enlistment (Entry) Program:

- (1) For a Regular Component. Service as an enlisted member in the Reserves before beginning active duty in a Regular component is creditable service if the member enlisted in the Reserve component before 1 Jan 1985.

- (2) For a Reserve Component. All service as an enlisted member in the Reserves before beginning initial active duty for training is creditable.

REPORT OF DUTY—STATE ACTIVE DUTY PERSONNEL

CODE

- D - DUTY STATUS
- A - ORDINARY (ANNUAL) LEAVE STATUS
- M - MILITARY LEAVE STATUS (INCLUDE MILITARY ORDERS)
- W - LEAVE WITHOUT PAY
- S - SICK LEAVE STATUS (INCLUDE OTAG FORM 600-1)
- H - HOLIDAY (DID NOT WORK ON THE HOLIDAY)
- HC - HOLIDAY CREDIT (WORKED ON A PREVIOUS HOLIDAY)
- J - JURY DUTY
- PH - PERSONAL HOLIDAY
- F - MILITARY FURLOUGH
- T - ADMINISTRATIVE TIME OFF (REQUIRES TAG APPROVAL)
- X - ADMINISTRATIVE LEAVE (With Pay)

NAME: _____

SSN: _____

LOCATION: _____

FROM: _____ TO: _____

ENTER
OTHER THAN
DUTY DAYS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

I certify that the attendances and absences recorded above are
Correct and that all leave was approved in accordance with existing laws and
regulations and that there has been no change in my dependency status for the
period concerned.

REMARKS:

EMPLOYEE SIGNATURE	DATE
COMMANDER/SUPERVISOR SIGNATURE	DATE

Federal Privacy Act Information Statement

The Board of Administration, Public Employee's Retirement System, requires the disclosure of each member's Social Security account number on a mandatory basis to comply with Sections 6033 and 6041, Title 26, of the United States Code, and Sections 1.603-1(a)(3) and 1.604-2(b) of the Federal Tax Regulations, requiring reporting to the Internal Revenue Service of disbursements made by the System and to comply with its obligations under the Federal-State agreement imposed by Sections 404.1242, 404.1243, 404.1250, 404.1255 and 404.1256, Title 20, Code of Federal Regulations, requiring reporting to the Social Security Administration.

The Social Security account number is used for the following purposes and is included in the following documents:

1. Member identification on membership files, documents, and correspondence.
2. Annual report to the Franchise Tax Board and to the Internal Revenue Service of interest on refunds where the interest paid to an individual is \$600 or more.
3. Annual Statement of Member Contribution and Service Credit sent to employers for distribution to members.
4. Annual Listing of Member Contributions as of each June 30 sent to each employer.
5. All Refund Rolls submitted to the State Controller for processing.
6. Reports of benefit payments to the State Franchise Tax Board and to the Internal Revenue Service.
7. Annual return filed with the Internal Revenue Service.
8. Reports to the Internal Revenue Service of Federal income tax withheld from benefit payments.
9. Reports submitted to the Social Security Administration.

I have read the foregoing on _____
(date)

(Signature)

STATE ACTIVE DUTY EVALUATION OF PERFORMANCE

PART I - ADMINISTRATIVE DATA

Last Name, First Name Middle Initial	SSN	SAD Grade	Position Title
Unit/Activity of Assignment			Period Covered

PART II - PERFORMANCE EVALUATION

PERFORMANCE FACTORS	RATING SCALE (See reverse for instructions)								COMMENTS
1. PRODUCTIVITY	0	1	2	3	4	5	N/A		
2. QUALITY OF WORK	0	1	2	3	4	5	N/A		
3. INITIATIVE	0	1	2	3	4	5	N/A		
4. WORKING RELATIONSHIPS	0	1	2	3	4	5	N/A		
5. ADAPTABILITY	0	1	2	3	4	5	N/A		
6. JUDGMENT	0	1	2	3	4	5	N/A		
7. INTEREST IN JOB	0	1	2	3	4	5	N/A		
8. ABILITY TO WORK INDEPENDENTLY	0	1	2	3	4	5	N/A		
9. ORAL EXPRESSION	0	1	2	3	4	5	N/A		
10. WRITING ABILITY	0	1	2	3	4	5	N/A		
11. CONFIDENCE IN OWN KNOWLEDGE & ABILITY	0	1	2	3	4	5	N/A		
12. SELF IMPROVEMENT	0	1	2	3	4	5	N/A		
13. ACCEPTS RESPONSIBILITY	0	1	2	3	4	5	N/A		
14. MOTIVATES OTHERS	0	1	2	3	4	5	N/A		
*15.	0	1	2	3	4	5			
GROSS TOTAL ALL COLUMNS:							**		

* Other performance factors directly related to the individual's position.

** Divide by number of rated elements x 10 = Evaluation Score

$$\text{---} \div \text{---} \times 10 = \text{Evaluation Score}$$

NARRATIVE COMMENT ON ALL RATINGS OF 0

SIGNATURE OF INDIVIDUAL	DATE
SIGNATURE OF RATER	TITLE
SIGNATURE OF REVIEWING OFFICER	TITLE
	DATE

INSTRUCTIONS

1. Review the elements carefully and select those that best describe the duties required to be performed by this employee. Enter the number of relevant elements in the appropriate box. For each element you select, the evaluation should be obtained by comparing this employee with other employees of the same grade and duty requirements. Be sure your evaluation is based either on actual observation of the employee's work or on the product (tangible or intangible) resulting from the employee's efforts. Use the scale of points included in the evaluation scale on the right of the form. The meaning of each point on the scale is as follows:

YOU ARE INDICATING THAT		
If your evaluation of the employee on an element is	The Employee's Performance on that element is	Among employees in his series & grade level you would place the employee
0	Marginal or below the expected level & that he/she requires further training or experience to bring his/her performance up to satisfactory level.	In the lowest 2%
1	Satisfactory	With 50% of the employees
2	Consistently satisfactory & sometimes above satisfactory	With employees in the upper 3rd quarter (Next 25%)
3	Consistently above satisfactory but not exceptional	In the lower portion of the top 23% (Next 14%)
4	Consistently above satisfactory and some times exceptional	In the lower portion of the top 9% (Next 6%)
5	Consistently exceptional	In the top 3%

INCOMPATIBLE ACTIVITIES STATEMENT

1. Each State agency is required to establish a statement of incompatible activities of employees and to advise employees periodically of those activities considered incompatible with State employment. The following activities are considered incompatible for State employees of the Military Department:

- a. Providing confidential information to persons to whom issuance of such information has not been authorized, or using confidential information for personal gain or advantage or for the advantage of others.
- b. Soliciting or accepting, directly or indirectly, any money, loan, employment, business, benefit or other thing of value (in addition to salary paid by the State) from anyone from whom it might be inferred as a gift to influence the State employee concerned.
- c. Engaging in any employment which will prevent prompt response to a call to report to duty as required by department heads.
- d. Providing, or using, the names of persons from office records for mailing list that has not been authorized.
- e. Providing, or using, unit station lists for use in circulation or advertising of articles or services.
- f. Using the prestige or influence of one's office for personal gain or advantage or for the advantage of others.
- g. Using State time, facilities, records, equipment or supplies for personal use or gain.
- h. Receiving or accepting money, gifts or favors for services rendered during State working hours.
- i. Performance of an unofficial act that may later be subject to the officer's control, inspection, review, audit or enforcement in an official State capacity.

2. In addition to the above activities, employees are also reminded that the Government Code of the State of California prohibits the use of any public office or employment to either aid or obstruct any person from obtaining any elected position or from nomination for an elected position.

3. In order to insure that all employees of the Department are aware of the incompatible activities the inclosure one is provided for each employee to acknowledge receipt of this letter. Signed acknowledgements should be returned to this headquarters, attention: CASS.

I acknowledge that I have read and understand the above statement.

Name

Activity, Section, Branch, or Installation

Date

State Active Duty Complaint Form

Date: _____

Name: _____

Position Title: _____

Division/Activity: _____

Section: _____

Description of Problem: (Attach additional pages if necessary)

Action Requested:

I discussed this with my Supervisor on _____. Signature: _____

COMPLAINT REVIEW - FIRST LEVEL

Date Received: _____

Supervisor's Decision: _____

Signature: _____

Title: _____

Date: _____

COMPLAINT REVIEW - SECOND LEVEL

Date Received: _____

Supervisor's Decision: _____

Signature: _____

Title: _____

Date: _____

COMPLAINT REVIEW

Date Received: _____

Decision: _____

Signature: _____

Title: _____

Date: _____

Statement of State Active Duty Status

1. The authority for State Active Duty is the California Military and Veterans Code. It directs that the duties of the Officers, Warrant Officers and Enlisted Personnel of the Office of the Adjutant General shall conform to the duties prescribed by regulations of the Department of Defense for like positions in the Army, Air Force and Navy. All activities or installations operated by the Military Department are considered extensions of the Office of the Adjutant General and the same provisions apply to State Active Duty employees at those locations.

2. All members appointed to State Active Duty, regardless of Military affiliation, are advised that:

- a. They are subject to call to duty 24 hours a day, seven days a week.
- b. There is no entitlement to compensatory time off.
- c. They are required to meet the same physical standards as prescribed for federally recognized National Guard members.
- d. They must attain and maintain professional proficiency.
- e. Federally recognized members of the National Guard will wear the appropriate Military Uniform while on duty and must comply with the appropriate military dress and grooming code.
- f. Assignment to State Active Duty requires a release of their medical records for review and adjudication by proper military and medical authority.
- g. Persons who are not appointed to permanent State Active Duty pursuant to CMVC 167 do not accrue any preferential rights in their employment status. In the event of a reduction in force, loss or decrease in funding, termination of a specific program or other event which affects their position, a person may be separated from State Active Duty status.
- h. They are subject to the Uniform Code of Military Justice as assimilated into State law.
- i. They may be prohibited from carrying forward accrued leave beyond a year as determined by the program director or other proper authority because of constraints and uncertainties related to program funding.

3. SAD MEDICAL RECORD RELEASE: I hereby release any and all of my medical records or reports to The Adjutant General or the State Personnel Programs Director of the California National Guard from any physician or treatment facility. This release is effective as long as I am performing State Active Duty with the California National Guard or am a member of the California Army or Air National Guard. I understand that this release is to provide information to The Adjutant General or a properly designated individual to ascertain my condition or ability to perform State Active Duty.

A photocopy of this release may serve as an original writing.

4. I acknowledge having read the above statement and agree to comply with the established provisions.

Printed Name:

Signature of Soldier/Airman:

Position Title:

Date:

Statement of Understanding

State Active Duty - Special Programs

1. I understand that I have been placed on orders to Temporary State Active Duty (SAD) pursuant to the California Military and Veterans Code (CMVC) Section 142.
2. I understand that I am subject to the Uniform Code of Military Justice as incorporated into the CMVC for purposes of military discipline.
3. I understand that temporary SAD is not a permanent status and that my orders may be administratively terminated as anytime if the need for personnel performing duty changes or if my performance is determined to be substandard.
4. I understand the personnel on SAD do not have a right or guarantee of continuation on orders beyond the duty date indicated on the initial order.

Printed Name:

Signature of Soldier/Airmen:

Position Title:

Date:

Employee Clearance Form

NAME	POSITION NUMBER	EFFECTIVE DATE OF CLEARANCE
TYPE OF ACTION		
_____ Transfer	_____ Separation	_____ Leave of Absence

Listed below are items that must be cleared prior to the release of final payment to the employee. It is the responsibility of the supervisor to discuss this with the employee, complete the form, and route it to State Personnel with the separation document.

SUPERVISOR

MANUALS/PUBLICATIONS:

_____ Dictionary

EQUIPMENT:

_____ Badge

_____ Tape Recorder

_____ Armory Equipment

_____ Keys, Locks

_____ Other _____

I have reviewed the records and have determined the above individual is cleared of all state property issued.

SUPERVISOR'S SIGNATURE

DATE

COMPTROLLER

ADVANCES:

_____ Salary

CREDIT CARDS:

_____ Airline

_____ Gasoline

_____ Travel

_____ Car Charge Card

_____ Telephone

_____ Accounts Receivable

_____ Other _____

I certify that records indicate there are no outstanding advances or accounts receivables and that all credit cards have been surrendered.

COMPTROLLER'S OFFICE SIGNATURE

DATE

PERSONNEL OFFICE USE ONLY

_____ OTAG 900-11
or
_____ STD 687

_____ Accrued Leave

_____ COBRA Eligibility Form

_____ Separation Orders

_____ PERS-ACC-167

REMARKS:

SAD Reduction in Force (RIF) Register

SAD Grade: _____

Date: _____

Name	Evaluation Score By RIF Board	Remarks
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

It is the determination of the Reduction in Force Board convened this date that the following named individual (s) be removed from SAD in the grade shown above:

- A. _____
- B. _____
- C. _____
- D. _____

The Adjutant General

Assistant Adjutant General

Deputy Adjutant General, Joint
Staff Division

Deputy Adjutant General, Army
Division

Deputy Adjutant General, Air Division

SAD Reduction in Force (RIF) Board Raters Score Sheet

NAME: _____ SAD Grade: _____

I. EFFICIENCY

Performance Evaluation Scores

Year 20 _____

20 _____

20 _____

20 _____

Total _____ + _____ = _____

II. POTENTIAL FOR PERFORMANCE

(Highly Qualified = 50; Well Qualified = 40; Qualified = 30; Marginally Qualified = 20
Not Qualified = 0)

Score Given _____

III. FITNESS

(Grade for each factor: Excellent = 30; Good = 20; Marginal = 10; Poor = 0)

Physical Fitness _____

Loyalty _____

Integrity _____

Total Score _____

IV. RATERS PERSONAL EVALUATION

Grant points for the rates personal evaluation of the individual's
Value to the National Guard: Outstanding = 50; Excellent = 40;
Good = 30; Average = 20; Below Average = 0

Score Given _____

Cumulative Score (240 Maximum) _____

SAD Information and Evaluation

Name: _____

SAD Grade: _____ Effective Date of Appointment: _____

Military Grade: _____

Primary Military Specialty: _____

Secondary Military Specialty: _____

Service:	Yrs	Mos
State Active Duty	_____	_____
Federal Active Duty	_____	_____
Technician (Calif)	_____	_____
Part Time NG (Calif) (other than counted above)	_____	_____

Age: _____ Date of Birth: _____

Eligible for immediate PERS Annuity: _____ Yes _____ No

Civilian Education:

Military Education:

SAD Effectiveness Report Ratings:
(A) (B) (C) (D)

YEARLY TRAINING PLAN

[illegible]

Training Request

SUBMITTED BY:		DATE:	THROUGH:	DATE:
TO: CAJS-SP		DATE:	DUTY LOCATION:	
NAME OF EMPLOYEE:		TYPE OF TRAINING:		
CLASSIFICATION/TITLE:		<input type="checkbox"/> Job required <input type="checkbox"/> Job related <input type="checkbox"/> Upward Mobility* <input type="checkbox"/> Career Related* *Attach appropriate justification.		
WHY IS TRAINING NEEDED? (New Program, New Technologies, Planned Development, etc.)				
COURSE TITLE/NUMBER:		ORGANIZATION/VENDOR:		
LOCATION OF TRAINING (Address):		TRAINING PERIOD:		TELEPHONE NUMBER:
TUITION COST:		FUNDING CODE:		
SUPERVISOR'S APPROVAL:				DATE:
ACTIVITY/DIRECTORATE/DIVISION APPROVAL:				DATE:

THIS SECTION FOR CASS USE ONLY

TO: CAJS-ST
CAJS-ST-PC

FROM: 'CAJS-SP

- ☐ Request revolving fund check be issued as indicated above.
☐ Request purchase order be issued as indicated above.

TRAINING OFFICER OR REPRESENTATIVE

TO:

FROM: CAJS-SP DATE:

- ☐ The above request has been approved and processed.
- ☐ The above request is disapproved for the following reason:

TRAINING OFFICER OR REPRESENTATIVE

ANNUAL TRAINING REPORT

[illegible]

TASK LISTING

1. CURRENT TITLE: _____
2. PROPOSED TITLE IF DIFFERENT: _____
3. MAJOR FUNCTION OF POSITION: _____

4. Description of duties to be performed: (List the duties first that will require the highest percentage of time. Group related duties together and give estimated percentage for each group).

[illegible]

5. List any machine, equipment, office appliances, or motor vehicles which might be used: _____
- _____
- _____
- _____
- _____

6. Identify by position title with whom frequent contacts might be made and purpose of contacts: _____

7. How are the majority of work assignments made:

- _____ Assigned by supervisor who instructs how to accomplish
- _____ Assigned by supervisor and incumbent decides how to accomplish
- _____ Incumbent will have responsibility for set of duties and will accomplish
- _____ Incumbent will develop projects as needed and accomplish

8. What percentage of work will be reviewed: (Percentage should be determined based on level of responsibility as indicated in seven above) _____

9. The most serious thing that could result from an error in the performance of duties: _____

10. Incumbent will supervise the following employees

<u>NAME</u>	<u>TITLE</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

11. Describe the nature and extent of supervisory responsibilities: (Plan work, prepare budget, assign and review work, evaluate performance, initiate action to fill vacancies and select employees, approve use of vacation, sick leave and other leave)

Information Acknowledgment Form

Acknowledgment of Receipt of Retirement Information

I have received the information and election package on
the State Miscellaneous or Industrial 2% at age 55 and
State Second Tier 1 $\frac{1}{4}$ % at age 65 retirement formulas (PERS-MSD-350).

Member Signature

Social Security Number

Member Printed Name

CalPERS Membership Date

Date

Employer

Daytime Telephone Number

This form must be completed, signed, and returned to your
personnel clerk who will forward it to CalPERS.
THIS IS NOT AN ELECTION DOCUMENT.

This information and election package was given to the above employee.

on: _____

Date

by: _____

Personnel Office Staff

()

Phone Number

Please return this form to:
California Public Employees' Retirement System
Member Services Division, Unit 841
P.O. Box 942704
Sacramento, CA 94229-2704

State of California

EMPLOYER'S REPORT
OF OCCUPATIONAL
INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail original and one copy to:

STATE COMPENSATION INSURANCE FUND

Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2 - 2581.5
for instructions on completion and routing.
BOTH SIDES OF THIS FORM MUST BE COMPLETEDOSHA
Case No.☐ FatalityPerson who makes or causes to be made any
knowingly false or fraudulent material statement
or material representation for the purpose of
obtaining or denying workers' compensation
benefits or payments is guilty of a felony.NOTICE: California law requires employers to report within five days of knowledge every occupational injury or illness
which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee
subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge
an amended report indicating death. In addition, every serious injury/illness, or death must be reported immediately by
telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.E
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1. DEPARTMENT		1A. AGENCY CODE OR SCIF POLICY NUMBER		DO NOT USE THIS COLUMN		
2. MAILING ADDRESS (Number and Street, City, ZIP)		2A. PHONE NUMBER		Case No.		
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)		3A. DIV./LOCATION CODE		Ownership		
4. NATURE OF BUSINESS Governmental Agency		5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.		Industry		
6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input checked="" type="checkbox"/> STATE <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____				Occupation		
7. EMPLOYEE NAME		CSID#	8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm/dd/yyyy)	Sex	
10. HOME ADDRESS (Number and Street, City, ZIP)		10A. PHONE NUMBER		Age		
11. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		12. OCCUPATION (Regular job title—No initials, abbreviations or numbers)		CBID#	13. DATE OF HIRE (mm/dd/yyyy)	Daily hours
14. EMPLOYEE USUALLY WORKS hours _____ days _____ total _____ per day per week weekly hours		14A. EMPLOYMENT STATUS (See instructions in 14A continued below.) regular full-time part-time temporary seasonal		14B. Under what class code of your policy were wages assigned?		Days per week
15. GROSS WAGES/SALARY \$ _____ per _____		16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tps, meals, lodging, overtime, bonuses, etc.)? <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO		16B. Under what class code of your policy were wages assigned?		Weekly hours
17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yyyy)		18. MILITARY TIME INJURY/ILLNESS OCCURRED		19. MILITARY TIME EMPLOYEE BEGAN WORK		20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yyyy)
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE LAST WORKED (mm/dd/yyyy)		23. DATE RETURNED TO WORK (mm/dd/yyyy)		24. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO		27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yyyy)		28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yyyy)
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.						Nature of injury
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)		30A. COUNTY		30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.		32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.		34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.		34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.		Sec. Source
35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.						Extent of Injury
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)				36A. PHONE NUMBER		
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)				37A. PHONE NUMBER		
38. ANOTHER PERSON RESPONSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO		39. PERS/STRS MEMBERS <input type="checkbox"/> YES <input type="checkbox"/> NO		40. ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING INDUSTRIAL DISABILITY LEAVE BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
14A. EMPLOYMENT STATUS CONT. (Check current status of employment, not status at time of injury.) <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> ON STRIKE <input type="checkbox"/> DISABLED <input type="checkbox"/> RETIRED <input type="checkbox"/> LAID OFF <input type="checkbox"/> OTHER						
Completed by (type or print)		Signature		Title		
				Date		

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury, DO NOT DELAY SUBMISSION OF THE REVERSE SIDE TO STATE FUND. Submit the form completed in its entirety to the Departmental Safety Coordinator within ten days of the injury.

EMPLOYEE'S NAME

UNIT

SOCIAL SECURITY NUMBER

SUPERVISOR'S REVIEW

Facts available lead me to believe this work injury was caused by and happened during State work.

From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment.

The facts do not indicate this claim of injury was work connected.

GIVE THE FACTS THAT JUSTIFY THE ITEMS CHECKED:

WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT SIMILAR ACCIDENTS? HAVE YOU TAKEN THESE STEPS? ☐ YES ☐ NO If no, explain.

I DO NOT HAVE AUTHORITY TO TAKE THE FOLLOWING ACTION BUT RECOMMEND:

IF INJURED EMPLOYEE IS UNABLE TO PERFORM FULL DUTY:

A. THE POSSIBILITY OF MODIFIED WORK WAS DISCUSSED WITH THE ATTENDING DOCTOR: ☐ YES ☐ NO

B. MODIFIED WORK DECISION: ☐ Condition precludes M.W. ☐ Appropriate M.W. not available ☐ M.W. arranged _____ days

Signature

Classification

Date

MANAGER'S REVIEW

DO YOU CONCUR WITH FIRST LINE SUPERVISOR'S REVIEW? ☐ YES ☐ NO If no, explain.

Signature and Date

CONTINUATION AND MISCELLANEOUS COMMENTS:

STATE COMPENSATION INSURANCE FUND ADJUSTING OFFICES

P.O. Box 9729
Bakersfield, CA 93389-9729

P.O. Box 91-1112
Commerce, CA 90091-1112

P.O. Box 4973
Eureka, CA 95502-4973

P.O. Box 40000
Fresno, CA 93755-4000

P.O. Box 9045
Oxnard, CA 93031-9045

P.O. Box 496049
Redding, CA 96049-6049

P.O. Box 59901
Riverside, CA 92517-1901

P.O. Box 1609
Rohnert Park, CA 94927-1609

P.O. Box 659011
Sacramento, CA 95865-9011

P.O. Box 1316
San Bernardino, CA 92402-1316

P.O. Box 530957
San Jose, CA 95153-5357



If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la Division de Compensación al Trabajador llamando al 1-800-736-7401. En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee: Empleado:

1. Name. Nombre. _____ Today's Date. Fecha de Hoy. _____
2. Home address. Dirección Residencial. _____
3. City. Ciudad. _____ State. Estado. _____ Zip. Código Postal. _____
- Date of Injury. Fecha de la lesión (accidente). _____ Time of injury. Hora en que ocurrió _____ a.m. _____ p.m.
5. Address and description of where injury happened. Dirección/lugar donde ocurrió el accidente. _____
6. Describe injury and part of body affected. Describa la lesión y parte del cuerpo afectada. _____
7. Social Security Number. Número de Seguro Social del Empleado _____
8. Signature of employee. Firma del empleado. _____

Employer - complete this section and give the employee a copy immediately as a receipt.
Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. Nombre del empleador. _____
10. Address. Dirección. _____
11. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. _____
12. Date claim form was provided to employee. Fecha en que se le entregó al empleado la petición. _____
13. Date employer received claim form. Fecha en que el empleado devolvió la petición al empleador. _____
14. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. STATE COMPENSATION INSURANCE FUND _____
15. Insurance Policy Number. El número de la póliza del Seguro. _____
- Signature of employer representative. Firma del representante del empleador. _____

17. Title. Título. _____ 18. Date. Fecha. _____ 19. Telephone. Teléfono. _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

Empleador: Se requiere que Ud. feche esta forma y que provea copias a su compañía de seguros, administrador de reclamos, o dependiente representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Aug 31, 2003

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

X ALL APPLICABLE BOXES:

6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	7.a. POSITION (Title, Grade, Component) 7.b. USUAL OCCUPATION
---	--	---	--

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
--	--

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		SOCIAL SECURITY NUMBER	
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.			
HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES NO	
<p>15.a. Dizziness or fainting spells <input type="radio"/> YES <input type="radio"/> NO</p> <p>b. Frequent or severe headache <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. A head injury, memory loss or amnesia <input type="radio"/> YES <input type="radio"/> NO</p> <p>d. Paralysis <input type="radio"/> YES <input type="radio"/> NO</p> <p>e. Seizures, convulsions, epilepsy or fits <input type="radio"/> YES <input type="radio"/> NO</p> <p>f. Car, train, sea, or air sickness <input type="radio"/> YES <input type="radio"/> NO</p> <p>g. A period of unconsciousness or concussion <input type="radio"/> YES <input type="radio"/> NO</p> <p>h. Meningitis, encephalitis, or other neurological problems <input type="radio"/> YES <input type="radio"/> NO</p>	<p>19. Have you been refused employment or been unable to hold a job or stay in school because of: <input type="radio"/> YES <input type="radio"/> NO</p> <p>a. Sensitivity to chemicals, dust, sunlight, etc. <input type="radio"/> YES <input type="radio"/> NO</p> <p>b. Inability to perform certain motions <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. Inability to stand, sit, kneel, lie down, etc. <input type="radio"/> YES <input type="radio"/> NO</p> <p>d. Other medical reasons (If yes, give reasons.) <input type="radio"/> YES <input type="radio"/> NO</p>		
<p>16.a. Rheumatic fever <input type="radio"/> YES <input type="radio"/> NO</p> <p>b. Prolonged bleeding (as after an injury or tooth extraction, etc.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. Pain or pressure in the chest <input type="radio"/> YES <input type="radio"/> NO</p> <p>d. Palpitation, pounding heart or abnormal heartbeat <input type="radio"/> YES <input type="radio"/> NO</p> <p>e. Heart trouble or murmur <input type="radio"/> YES <input type="radio"/> NO</p> <p>f. High or low blood pressure <input type="radio"/> YES <input type="radio"/> NO</p>	<p>20. Have you ever been treated in an Emergency Room? (If yes, for what?) <input type="radio"/> YES <input type="radio"/> NO</p>		
<p>17.a. Nervous trouble of any sort (anxiety or panic attacks) <input type="radio"/> YES <input type="radio"/> NO</p> <p>b. Habitual stammering or stuttering <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. Loss of memory or amnesia, or neurological symptoms <input type="radio"/> YES <input type="radio"/> NO</p> <p>d. Frequent trouble sleeping <input type="radio"/> YES <input type="radio"/> NO</p> <p>e. Received counseling of any type <input type="radio"/> YES <input type="radio"/> NO</p> <p>f. Depression or excessive worry <input type="radio"/> YES <input type="radio"/> NO</p> <p>g. Been evaluated or treated for a mental condition <input type="radio"/> YES <input type="radio"/> NO</p> <p>h. Attempted suicide <input type="radio"/> YES <input type="radio"/> NO</p> <p>i. Used illegal drugs or abused prescription drugs <input type="radio"/> YES <input type="radio"/> NO</p>	<p>21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) <input type="radio"/> YES <input type="radio"/> NO</p>		
<p>18. FEMALES ONLY. Have you ever had or do you now have: <input type="radio"/> YES <input type="radio"/> NO</p> <p>a. Treatment for a gynecological (female) disorder <input type="radio"/> YES <input type="radio"/> NO</p> <p>b. A change of menstrual pattern <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. Any abnormal PAP smears <input type="radio"/> YES <input type="radio"/> NO</p> <p>d. First day of last menstrual period (YYYYMMDD) <input type="radio"/> YES <input type="radio"/> NO</p> <p>e. Date of last PAP smear (YYYYMMDD) <input type="radio"/> YES <input type="radio"/> NO</p>	<p>22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) <input type="radio"/> YES <input type="radio"/> NO</p>		
	<p>23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) <input type="radio"/> YES <input type="radio"/> NO</p>		
	<p>24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) <input type="radio"/> YES <input type="radio"/> NO</p>		
	<p>25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) <input type="radio"/> YES <input type="radio"/> NO</p>		
	<p>26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) <input type="radio"/> YES <input type="radio"/> NO</p>		
	<p>27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) <input type="radio"/> YES <input type="radio"/> NO</p>		
	<p>28. Have you ever been denied life insurance? <input type="radio"/> YES <input type="radio"/> NO</p>		
<p>29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)</p>			

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		SOCIAL SECURITY NUMBER
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>		
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>		c. SIGNATURE
		d. DATE SIGNED <i>(YYYYMMDD)</i>

CALIFORNIA STATE PERSONNEL BOARD
STATE EMPLOYEE RACE/ETHNICITY QUESTIONNAIRE

(For All New Hires And Rehires)
 SPB 1070 Sl Empl Race/Ethnic Quest (11/89)

DATE: _____

INSTRUCTIONS:

1. This self-identification questionnaire is part of the new employee package. Self-identification means each employee has the opportunity to select which race/ethnic group he/she most closely identifies with. Complete promptly and return to your Department Personnel Office with your other hiring documents (NOT to the State Personnel Board).

DEPARTMENT NAME	EMPLOYEE'S NAME (print)	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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2. Please check the one box below which best describes your race/ethnicity and enter the one letter chosen on this line: _____

If Hispanic, check:

(Hispanic does not include persons of Portuguese or Brazilian origin or persons who acquired a Spanish surname)

- A. ☐ Mexican, Mexican/American, Chicano
 B. ☐ Puerto Rican
 C. ☐ Cuban
 D. ☐ Any Other Spanish/Hispanic

 (Specify)

If not Hispanic choose from the following:

- E. ☐ White
 F. ☐ Black
 G. ☐ Filipino

If American Indian, check:

(Member of an American Indian tribe or band recognized by the Federal Bureau of Indian Affairs; or has at least one-quarter blood quantum of tribes or bands indigenous to the United States or Canada (SPB Rule 547.34 requires written verification of American Indian ancestry at time of employment))

- H. ☐ American Indian

 (Specify Tribe)

- N. ☐ Eskimo
 O. ☐ Aleut

If Asian, check:

- I. ☐ Japanese
 J. ☐ Chinese
 K. ☐ Korean
 L. ☐ Vietnamese
 M. ☐ Asian Indian
 S. ☐ Other Asian

 (Specify)

- U. ☐ Cambodian
 V. ☐ Laotian

If Pacific Islander, check:

- P. ☐ Hawaiian
 Q. ☐ Samoan
 R. ☐ Guamanian/Chamorro
 T. ☐ Other Pacific Islander

 (Specify)

- X. ☐ Other, not listed

 (Specify)

3. Please check the method of identification ☐ A. Self-identification ☐ B. Department Designation (This is only used if the employee does not self-identify.)

UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE EXAMINED THIS STATEMENT AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, AND COMPLETE.

 EMPLOYEE SIGNATURE

 DATE

 SIGNATURE OF DEPARTMENT REPRESENTATIVE WHO REVIEWED
 AND APPROVED THE EMPLOYEE SELF-DESIGNATION.

 DATE

PRIVACY STATEMENT

AGENCY NAME:

State Personnel Board

UNIT RESPONSIBLE
 FOR MAINTENANCE:

The Personnel Office of the employing State department.

AUTHORITY/PURPOSE:

Government Code Section 19792 states that "The State Personnel Board shall: (h) Maintain a statistical information system designed to yield the data and the analysis necessary for the evaluation of progress in affirmative action and equal employment opportunity with the state civil service..."

The data is encoded by the department Personnel Office and becomes part of the Employment History System kept by the State Controller's Office. It is shared only with the State Personnel Board and the employing department and may be used for statistical purposes in the selection, layoff, or judicial processes. No other disclosures on an individual identifiable basis are made.

PROVIDING INFORMATION:

Each employee should indicate with which race/ethnic group they most closely identify.

EFFECTS OF NOT PROVIDING
 THE INFORMATION:

If an employee fails to self-identify, another method of identification will be used by the State Personnel Board since Government Code Section 19792 requires the collection of race/ethnic origin from all employees.

ACCESS:

Individuals can access their records through their Personnel Office.

DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANTS (Gov. C., Sec. 12479)

STD. 243 (REV. 2-95)

Submit two copies of a completed form
STD. 243 with original signatures to
your personnel/payroll office.

EMPLOYEE NAME (First, Middle, Last)	SOCIAL SECURITY NUMBER
NAME OF EMPLOYING STATE AGENCY	CITY WHERE AGENCY LOCATED

Pursuant to Section 12479 of the Government Code, I hereby designate the following person who, notwithstanding any other provision of the law, shall be entitled **upon my death** to receive all state warrants that would have been payable to me had I survived. NOTE: Direct deposit payments are not subject to the provisions of this designation.

Important: This is NOT a designation for payment of death benefits and refund of employee retirement contributions. A form STD. 241, Beneficiary Designation (PERS), must be completed to file a designation with the Public Employees' Retirement System for death benefits.

DESIGNEE (Must be 18 years of age or older)

DESIGNEE NAME (First, Middle, Last)	SOCIAL SECURITY NUMBER	AGE	TELEPHONE NUMBER
ADDRESS	CITY AND STATE	ZIP CODE	

I hereby revoke any previous designations filed by me.

If the above-named designee does not file a written request with the personnel/payroll office of my employing state agency/campus for such warrants within sixty (60) days after the date of my death, this designation shall be and become null and void.

This designation will remain in full force and effect during my employment with any California state agency/campus until revoked in writing by me.

EMPLOYEE HOME ADDRESS		FOR AGENCY/CAMPUS USE ONLY	
CITY, STATE, ZIP CODE		REVIEWED BY THE PERSONNEL/PAYROLL OFFICE AND FILED	
EMPLOYEE SIGNATURE (Please sign both copies in ink)		SIGNATURE OF AUTHORIZED OFFICER	
DATE SIGNED		TYPED NAME	
		DATE	

INSTRUCTIONS

- Complete this form in duplicate; typewritten or in ink.
- Show designee's full name; for example, "Mary Jane Smith," not Mrs. John E. Smith.
- Verify that the form is complete and correct. No erasures or corrections may be made in the name of the designee. If any error has been made, complete a new set of forms.
- Sign both copies in ink. Submit both copies to your personnel/payroll office. The duplicate copy will be returned to you for your records.
- You may change your designation at any time by filing a new form STD. 243 with your personnel/payroll office.
- You may completely revoke a designation at any time by submitting either a new form STD. 243 indicating "NONE" for the designee name or a letter to your employer. Two copies with original signatures are required.
- Inform your personnel/payroll office when a change occurs in your designee's address.
- You may wish to file a new designation upon any change in your marital status.

PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the employing personnel/payroll office for the sole purpose of identifying the designee authorized to receive warrants payable to the employee had he/she survived.

Legal references authorizing maintenance of this information include the Government Code Section 12479 and the State Administrative Manual Section 8477.1-8477.27.

This form and all personal information contained therein is maintained by the employing personnel/payroll office. Employees have the right of access to copies of their Designation of Person Authorized to Receive Warrants form upon request.

REQUEST FOR NONDISCLOSURE OF EMPLOYEE HOME ADDRESS

STD. 677 (NEW. 2-99)

PLEASE TYPE OR USE BALL POINT PEN - PRINT CLEARLY

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER
------------------------------------	------------------------

Pursuant to Government Code Section 6254.3:

- (a) The home addresses and home telephone numbers of state employees of a school district or county office of education shall not be deemed to be public records and shall not be open to public inspection, except that information may be made as follows:
- (1) To an agent, or a family member of the individual to whom the information pertains.
 - (2) To an officer or employee of another state agency, school district, or county office of education when necessary for the performance of its official duties.
 - (3) To an employee organization pursuant to regulations and decisions of the Public Employment Board, except that the home addresses and home telephone numbers of employees performing law enforcement-related function shall not be disclosed.
 - (4) To an agent or employee of a health benefit plan providing health services or administering claims for health services to state, school districts, and county office of education employees and their enrolled dependents, for the purpose of providing the health services or administering claims for employees and their enrolled dependents.
- (b) Upon written request of any employee, a state agency, school district, or county office of education shall not disclose the employee's home address or home telephone number pursuant to paragraph (3) of subdivision (a) and an agency shall remove the employee's home address and home telephone number from any mailing list maintained by the agency, except if the list is used exclusively by the agency to contact the employee.

CHECK APPROPRIATE BOX

- ☐ I request that my home address not be disclosed as provided by Government Code Section 6254.3(b). I understand that my home address can be disclosed to specified individuals or organizations under Government Code Sections 6254.3.
- ☐ I cancel my previous request of having my home address not be disclosed.

PRIVACY NOTICE

The information Practices Act of 1977 (California Civil Code Section 1798.17) and the Federal Privacy Act (5 USC 552a, subd. (e)(3)) require this notice to be provided when collecting personal information from individuals. Information requested on this form, which includes the social security number, is used for the purposes of identification and the address withhold processing. Furnishing the requested information on this form is mandatory. Failure to provide the mandatory information may result in the address withhold action not being processed or being processed incorrectly.

Legal references authorizing the maintenance of this information include: Federal Internal Revenue Code (26 USC Sections 3402(a), 6011, 6051, and 6109) and the regulations thereto; and California Government Code Sections 12470 through 12479 and 16391 through 16395; delegated authority from the State Personnel Board; and delegated authority from the Trustees of the California State University.

Employees have the right to review their own personal information maintained by the State Controller's Office unless access is denied by law. Contact: Personnel/Payroll Service Division, State Controller's Office, P.O. Box 942850, Sacramento, CA 94250-5878.

EMPLOYEE SIGNATURE	DATE SIGNED
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PERSONNEL OFFICE USE ONLY

REVIEWER'S SIGNATURE	TELEPHONE NUMBER ()	DATE REVIEWED
AGENCY	UNIT	KEYED BY
		DATE KEYED

EMPLOYEE ACTION REQUEST

PERSONNEL OFFICE USE

Who is authorized to receive your pay warrant in case of death? Contact your personnel office to update your designee's name or address (Form STD, 243). See also retirement beneficiary information on reverse side of employee copy.

STD. 686 (REV. 7-99)

CHECK ONE OR MORE BOX(ES) AND COMPLETE LISTED SECTIONS. RETURN COMPLETED FORM TO YOUR PERSONNEL OFFICE. USE BALL POINT PEN AND PRINT CLEARLY. NO CARBON REQUIRED.

B 01 <input type="checkbox"/> New Employee SECTIONS C, E, F, G, H, I	<input type="checkbox"/> Withholding Allowance Change SECTIONS C, E, I	<input type="checkbox"/> *Address Change SECTIONS C, F, I	<input type="checkbox"/> Name Change (Attach Substantiation) SECTIONS C, D, I	<input type="checkbox"/> Birthdate Correction SECTIONS C, H, I
---	--	---	--	--

NOTE: Social Security Number and Last Name, First Name, and Middle Initial must be entered exactly as shown on Social Security card.	
01 SOCIAL SECURITY NUMBER	02 EMPLOYEE LAST NAME
03 FIRST NAME AND MIDDLE INITIAL	
FORMER NAME (Last, First and Middle)	

WITHHOLDING ALLOWANCE CHANGE OR NEW EMPLOYEE

IMPORTANT Before completing Section E, you must read IRS Form W-4 and the applicable state tax form. (For California use Form DE-4.)

E I. FEDERAL AND STATE ALLOWANCE - For Tax Purposes Only. If no tax should be withheld, complete Part IV or V only. 01 MARITAL STATUS FOR TAX PURPOSES ONLY (Check One) <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED 02 <input type="checkbox"/> TOTAL - Number of allowances you are claiming NOTE: Employers must notify IRS if more than 10 allowances are claimed.	III. ADDITIONAL DEDUCTIONS - Complete box 06 and/or 07 if you wish additional Federal and/or State tax withheld from your wages. Part I (and Part II, if your State allowance claim differs from your Federal) must be completed. The first deduction will be made from your earnings for the pay period in which this form is processed. IF BOXES ARE NOT COMPLETED, CURRENT DEDUCTIONS (IF ANY) WILL BE CANCELLED. I hereby authorize the State Controller to deduct monthly from my wages the additional Federal and/or State tax amount specified below. I understand that if boxes are not completed, current deductions, if any, will be cancelled. 06 <input type="checkbox"/> FEDERAL ADDITIONAL DEDUCTION 07 <input type="checkbox"/> STATE ADDITIONAL DEDUCTION
II. SPECIAL TREATMENT OF STATE ALLOWANCES - Complete boxes 03 thru 05 if you wish your State withholding to be different than what you claim for Federal withholding. IF BOXES ARE NOT COMPLETED, CURRENT SPECIAL TREATMENT (IF ANY) WILL BE CANCELLED. 03 MARITAL STATUS FOR TAX PURPOSES ONLY (Check One) <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED 04 <input type="checkbox"/> REGULAR ALLOWANCE(S) Total you are claiming 05 <input type="checkbox"/> ADDITIONAL ALLOWANCE(S) Total you are claiming NOTE: Employers may be required to notify EDD if more than 10 allowances are claimed.	IV. EXEMPTION FROM WITHHOLDING - Check box 08 if you are eligible to claim exemption from withholding. No Federal or State income tax will be withheld from your wages. DO NOT COMPLETE PARTS I, II OR III. (See General Information on back of third page.) 08 <input type="checkbox"/> I claim exemption from withholding because of no tax liability. Last year I did not owe any income tax and had a right to a full refund of ALL income tax withheld, AND this year I do not expect to owe any income tax and expect to have a right to a full refund of ALL income tax withheld. NOTE: This exemption will automatically expire on February 15 of next year unless you file a new certification by January 31 of next year. Employers are required to notify IRS if you earn more than \$200 per week. V. NONTAXABLE WAGES - Check box 09 if wages you will receive are not subject to income tax withholding. 09 <input type="checkbox"/> I claim that the wages I will be receiving from the State are either a 1) MINISTER OF A CHURCH in the exercise of his/her ministry, 2) NONIMMIGRANT ALIEN wages, or 3) DECEASED EMPLOYEE WAGES. Indicate reason (See General Information on back of third page.):

ADDRESS CHANGE OR NEW EMPLOYEE *See Back of Third Page

01 EMPLOYEE ADDRESS (Street, Rural Route or P.O. Box)	02 CITY	03 STATE	04 ZIP CODE
04 EMPLOYMENT LIST			
<input type="checkbox"/> Check this box if your address is changing and your name appears on any departmental employment list. (See back of third page.)			

NEW EMPLOYEE THIS INFORMATION MAY BE USED TO LOCATE PRIOR PUBLIC EMPLOYMENT SERVICE FOR STATE SERVICE CREDITS AND/OR RETIREMENT SYSTEM BENEFITS.

01 LAST EMPLOYED BY CALIFORNIA STATE AGENCY OR CAMPUS OF:	01 LAST NAME (if different)	02 SEPARATED	03 LAST NAME (if different)	04 SEPARATED
		MO	MO	YR

NEW EMPLOYEE OR BIRTHDATE CORRECTION EMPLOYEE SIGNATURE

H BIRTHDATE	I EMPLOYEE SIGNATURE	J REVIEWER'S SIGNATURE
MO DAY YR	DATE	DATE
I certify that the above information is true and correct and that I have read the IRS Form W-4 and the applicable state form. Under the penalties of perjury, I certify that the number of withholding exemptions and allowances claimed on this certificate does not exceed the number to which I am entitled. If claiming exemption from withholding, I certify that I incurred no tax liability for last year and that I anticipate that I will incur no liability this year.		PHONE NO.

PERSONNEL OFFICE USE

SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS

Use ballpoint pen and return completed form to your Personnel Office.

PERSONNEL OFFICE USE		
A	01 AGENCY	02 UNIT
	03 ADD'L IDENTIFICATION	

03 FIRST NAME AND MIDDLE INITIAL

02 EMPLOYEE LAST NAME

B

SEPARATION DATE AND TYPE OF SEPARATION (Check One)

01 SEPARATION DATE		02 RESIGNATION		03 SEPARATION WITHOUT FAULT BY DEPARTMENT OR CAMPUS		04 OTHER	
MONTH	DAY	YEAR					
REASON FOR RESIGNATION							

This resignation is executed by me freely and voluntarily and of my own free will and is not given by reason of any threat, force, duress, or any undue influence by any person (Sign in Section G).

DISPOSITION OF CALPERS CONTRIBUTIONS (Check One Box Only) IF YOU ARE RETIRING, DO NOT COMPLETE THIS SECTION

D TO TERMINATE MEMBERSHIP--To be eligible for a refund you must have service under the first tier and be permanently separating from ALL CALPERS-covered employment. Before checking either box, read the information contained in Section A on the reverse side of the employee copy.		ELECT TO TERMINATE MY MEMBERSHIP IN CALPERS AND DIRECTLY RECEIVE A REFUND OF MY TOTAL CONTRIBUTIONS. I UNDERSTAND THAT 20% OF THE TAXABLE AMOUNT WILL BE WITHHELD FOR FEDERAL INCOME TAXES AS DESCRIBED IN THE ATTACHED BAS-500 FORM.	
01	<input type="checkbox"/>	04	
ELECT TO TERMINATE MY MEMBERSHIP IN CALPERS AND DIRECTLY ROLLOVER THE TAXABLE PORTION OF MY TOTAL CONTRIBUTIONS TO THE FINANCIAL INSTITUTION OR PLAN NAMED ON THE CALPERS DIRECT ROLLOVER ELECTION, ATTACHED.		ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND ESTABLISH RECIPROCITY (AS EXPLAINED IN SECTIONS D AND E ON THE REVERSE SIDE OF THE EMPLOYEE COPY) BY ACCEPTING EMPLOYMENT WITH THE FOLLOWING PUBLIC AGENCY, WHICH PROVIDES MEMBERSHIP IN ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM.	
02	<input type="checkbox"/>	04	
ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND LEAVE MY CONTRIBUTIONS AND/OR SERVICE CREDIT ON DEPOSIT.		ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND ESTABLISH RECIPROCITY (AS EXPLAINED IN SECTIONS D AND E ON THE REVERSE SIDE OF THE EMPLOYEE COPY) BY ACCEPTING EMPLOYMENT WITH THE FOLLOWING PUBLIC AGENCY, WHICH PROVIDES MEMBERSHIP IN ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM.	
03		04	
ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND LEAVE MY CONTRIBUTIONS AND/OR SERVICE CREDIT ON DEPOSIT.		ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND ESTABLISH RECIPROCITY (AS EXPLAINED IN SECTIONS D AND E ON THE REVERSE SIDE OF THE EMPLOYEE COPY) BY ACCEPTING EMPLOYMENT WITH THE FOLLOWING PUBLIC AGENCY, WHICH PROVIDES MEMBERSHIP IN ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM.	

TO CONTINUE MEMBERSHIP--Contributions, if any, will continue to earn interest, and you will not accrue further service unless you return to CalPERS-covered employment. If you have five (5) years of service credit and elect to leave your contributions on deposit, you can apply for service retirement at age 50 and receive a monthly allowance. For a retirement estimate, use the "calculator" on CalPERS' website at www.calpers.ca.gov. Before checking either box, read the information contained in Sections B through D on the reverse side of the employee copy.

03 I ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND LEAVE MY CONTRIBUTIONS AND/OR SERVICE CREDIT ON DEPOSIT.

04

ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND ESTABLISH RECIPROCITY (AS EXPLAINED IN SECTIONS D AND E ON THE REVERSE SIDE OF THE EMPLOYEE COPY) BY ACCEPTING EMPLOYMENT WITH THE FOLLOWING PUBLIC AGENCY, WHICH PROVIDES MEMBERSHIP IN ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM.

(Enter name of Public Agency/Retirement System/University of California)

CALIFORNIA STATE TAX WITHHOLDING (Before checking either box, read the information contained in the form BAS-500)

ELECT TO HAVE 2% OF THE TAXABLE PORTION WITHHELD FOR STATE INCOME TAX (APPLICABLE TO OUT-OF-STATE RESIDENTS ALSO)

01	<input type="checkbox"/>	YES	OR	02	<input type="checkbox"/>	NO
----	--------------------------	-----	----	----	--------------------------	----

MAILING ADDRESS--Your Wage and Tax Statement (Form W-2) and any final warrants and/or retirement refund will be mailed to the address entered below.

01 EMPLOYEE ADDRESS (Street, Rural Route or P.O. Box)		02 CITY		STATE		03 ZIP CODE	
---	--	---------	--	-------	--	-------------	--

EMPLOYEE SIGNATURE/SPOUSAL SIGNATURE--Spouse's signature is required for refund election. IMPORTANT--If not signed, the Justification for Nonsignature form must be completed.

EMPLOYEE: I certify that the above information is true and correct.		DATE SIGNED		SPOUSE'S SIGNATURE		DATE SIGNED	
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X

PERSONNEL OFFICE USE

REASON FOR EMPLOYEE'S UNAVAILABILITY

01 ☐ EMPLOYEE UNAVAILABLE for completion of Section D. The employee has been advised that he/she must request the disposition of his/her retirement contributions in writing directly from CalPERS.

02 Enter the last date CalPERS contributions were or will be deducted from employee's pay. See instruction box in PAM or CSU PERS Manual

LAST DATE OF CONTRIBUTIONS	
MO	DAY
	YR

REVIEWER'S SIGNATURE

DATE SIGNED

PHONE

PINK--Employee

YELLOW--Personnel

WHITE--Personnel/Payroll Services/Person

DISTRIBUTION:

OATH OF ALLEGIANCE AND DECLARATION OF PERMISSION TO WORK FOR PERSONS EMPLOYED BY THE STATE OF CALIFORNIA

STD. 689 (REV. 7-75)

(Complete Parts 1 and 3 or Parts 2 and 3)

PART 1 - OATH OF ALLEGIANCE

WHO MUST SIGN OATH - Every State employee before he/she enters upon the duties of his/her State employment, except legally employed noncitizens. The oath is not required of noncitizens; however, the Declaration of Permission to Work is required. If an alien employee becomes a naturalized citizen, an oath must then be obtained and filed.

WHEN OATH MUST BE SIGNED - Before entering upon the duties of their employment. For intermittent, temporary or emergency employments an oath or affirmation may, at the discretion of the employing agency, be effective for all successive periods of employment which commence within one calendar year from the date of the oath.

WHERE OATHS ARE FILED - All oaths for State employees, State Civil Defense Volunteers, members of the California National Guard or California Defense and Security Corps shall be filed in the official employee file within 30 days of the date the oath is executed.

FAILURE TO SIGN OATH - No compensation or reimbursement for expenses incurred shall be paid to any public employee or civil defense worker by any public agency unless such public employee or civil defense worker has taken and subscribed to the oath or affirmation.

PENALTIES (Government Code)

"3108. Every person who, while taking and subscribing to the oath or affirmation required by this chapter, states as true any material matter which he/she knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison not less than one nor more than 14 years."

(TYPE OR PRINT NAME OF EMPLOYEE)

I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

PART 2 - DECLARATION OF PERMISSION TO WORK

I am a lawful permanent resident alien of the United States.

☐ YES ☐ NO

If NO, please read the following:

I hereby certify, that I have permission to work in this country and have declared any restrictions placed upon me in this regard by the United States government to the appointing power.

PART 3 - SIGNATURE AND CERTIFICATION (NO FEE MAY BE CHARGED FOR ADMINISTERING)

SIGNATURE OF EMPLOYEE



STATE DEPARTMENT OR AGENCY

SUBDIVISION OR UNIT

Taken and subscribed before me this

_____ day of _____

SIGNATURE OF AUTHORIZED OFFICIAL



TITLE

(SEAL)

Oath may be administered by a person having general authority by law to administer oaths - or may be administered by the appointing power, or by a person for whom written authorization to witness oaths has been executed by the appointing power. The appointing power maintains a file of such authorizations.

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 6-2000)

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A				SECTION B													
1. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME <i>(Complete Sections A, B, and D)</i> <input type="checkbox"/> CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES <i>(Complete Sections A, C, and D)</i> <input type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE <i>(Complete Sections A, B, C, and D)</i>				1. NAME OF DENTAL PLAN 2. PROVIDER/FACILITY NUMBER <i>(If applicable)</i> 3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.													
2. SOCIAL SECURITY NUMBER		3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER		ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN <i>(include self)</i> (First) (Middle) (Last)			DATE OF BIRTH MONTH DAY YEAR		FAMILY RELATIONSHIP							
4. NAME (First) (Middle) (Last)																	
ADDRESS (Number and Street)																	
(City, State, and Zip)																	
5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>		6. MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER		7. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					SELF								
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)																	
1. PRIOR DENTAL PLAN NAME																	
SECTION D 1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN <i>(Keep in employee's file)</i> <input type="checkbox"/> I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE																	
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE <i>(See Privacy Information on reverse of employee copy.)</i>								3. DATE SIGNED									
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)																	
1. EMPLOYER DED. CODE		2. DENTAL ORG. CODE		3. EMPLOYEE or COBEN DEDUCTION AMOUNT		4. PARTY CODE		5. STATE SHARE AMOUNT		6. PAY PERIOD		7. EMPLOYEE DESIGNATION		8. BARGAINING UNIT		9. TOTAL PREMIUM AMOUNT	
<input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351				\$				\$		MONTH YEAR						\$	
COMPLETE ON CHANGES ONLY				12. PERMITTING EVENT DATE		13. PERMITTING EVENT CODE		14. EFFECTIVE DATE OF ACTION		15. AGENCY CODE		16. UNIT CODE		17. AGENCY NAME OR RETIREMENT SYSTEM <i>(If Retired)</i>			
10. PRIOR EMPLOYER DED. CODE		11. PRIOR DENTAL ORG. CODE		11. PRIOR PARTY CODE				MONTH DAY YEAR		MONTH DAY YEAR							
<input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351								- 1 -									
18. REMARKS								19. AUTHORIZED AGENCY SIGNATURE <i>I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.</i> <input type="checkbox"/>									
								20. TELEPHONE NUMBER <i>(Indicate if CALNET or give Area Code)</i>				21. DATE RECEIVED IN EMPLOYING OFFICE					
												MONTH DAY YEAR					

WHITE - To Controller

YELLOW - To Carrier

PINK - To Agency

GREEN - To Employee

PRIVACY STATEMENT: Providing the social security account number is voluntary in accordance with the Privacy Act of 1974 (PS 93-579). If, however, the social security account number is not included, it may result in a delay or in our inability to comply with your request.

A. **EMPLOYEE INFORMATION**--Please note that you are not eligible to apply for a refund until 90 days after you retire or separate from all State employment. If this application is received by our office before you become eligible for payment, it will not be processed until the month following the 90-day period.

SOCIAL SECURITY NUMBER (See Privacy Statement)		BIRTHDATE	TELEPHONE NUMBER
<input type="text"/>		<input type="text"/>	<input type="text"/>
NAME (Last)	(First)	(M.I.)	RETIREMENT / SEPARATION DATE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ADDRESS (Number, Street, Apt. Number)			
<input type="text"/>			
CITY	STATE	ZIP CODE	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

B. COMMENCEMENT DATE ELECTION--You may choose to receive your lump-sum payment as soon as possible (after the 90-day waiting period) or at a future date you have elected. Payment cannot be deferred beyond age 70 1/2.

INDICATE WHEN YOU WOULD LIKE PAYMENT ISSUED

☐ ISSUE PAYMENT AS SOON AS POSSIBLE

☐ ISSUE PAYMENT

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Month Year

C. **CERTIFICATION—YOU MUST OBTAIN RETIREMENT VERIFICATION FROM YOUR PERSONNEL OFFICE** or provide a copy of Notice of Personnel Action Report of Separation (NOPA) you will receive approximately three weeks after your last working day. Return this Application and, if applicable, the NOPA to the Savings Plus Program office at the address listed at the top of this Application.

IMPORTANT: Your Application will NOT be processed for payment if you do not attach your NOPA, or if Section D has not been signed by your Personnel Office. Additionally, you must also include a copy of your photo identification and social security card.

I understand pursuant to Federal Regulations, the election of a commencement date is **FINAL AND IRREVOCABLE** and it is within the authority of the State of California to approve or disapprove this request. I declare, under penalty of perjury, pursuant to the laws of the State of California, that the foregoing is true and correct.

Signature

Date signed

D. RETIREMENT/SEPARATION VERIFICATION (Obtain from YOUR Personnel Office—see notes in Section C above)

I certify that this employee is retired/separated from State service effective: _____

If more information is needed, please contact me at:

AUTHORIZED DEPARTMENT REPRESENTATIVE (Please Print or Type)	SIGNATURE 	DATE SIGNED
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Payment Information

- Payment Information**
1. Payments are mailed to the address you have provided on this Application. (See Section A above.) Payments will not be made unless this Application and the NOPA are received by the Savings Plus Program office at least 30 days before the payment is scheduled for mailing date.
 2. Payments are made in a lump sum. Income taxes will NOT be withheld IF your account balance is less than \$2,500. If account exceeds \$2,500, taxes will be mandatorily withheld at the rate of 15% for Federal and NONE for State. In January of the following year, a W-2, Wage and Tax Statement, will be mailed to the address you have provided on this Application.



ENROLLMENT AUTHORIZATION

STD. 699 (Rev. 1-98)

- COMPLETION INSTRUCTIONS AND PRIVACY NOTICE ARE ON THE REVERSE OF THE EMPLOYEE COPY. PLEASE TYPE OR USE BALL POINT PEN—PRINT CLEARLY.

This authorization remains in full force and effect until the State Controller's Office receives written notification from the employee of its termination, or until the State Controller's Office or appointing authority deems it necessary to terminate the agreement.

SECTION A (To be completed by employee)

1. TYPE OF ENROLLMENT ACTION	2. SOCIAL SECURITY NUMBER
1. <input type="checkbox"/> NEW	3. NAME (First Middle Last)
2. <input type="checkbox"/> CHANGE	
3. <input type="checkbox"/> CANCEL	

SECTION B (To be completed by employee if NEW or CHANGE box in Section A is checked)

1. TYPE OF ACCOUNT <input type="checkbox"/> C (Checking) <input type="checkbox"/> S (Savings)	
Verify Routing/Depositor Numbers with Financial Institution	
2. ROUTING NUMBER	3. DEPOSITOR ACCOUNT NUMBER
4. FINANCIAL INSTITUTION NAME	
5. FINANCIAL INSTITUTION ADDRESS (Number and Street City State ZIP)	

SECTION C (To be completed by employee)

1. CHECK APPROPRIATE BOX	
<input type="checkbox"/> I hereby authorize the State Controller's Office to provide for direct deposit of any salary or wages due me, less any mandatory or authorized withholding or deductions therefrom, in the above designated account. If at any time the amount of salary or wages so deposited exceeds the amount of salary or wages actually due and payable to me, I hereby authorize the State Controller's Office to either: (a) Withhold a sum equal to the overpayment from future salary or wages; or (b) Recover such overpayment from the above-designated account. If the State is legally obligated to withhold any part of my wage or salary payment for any reason, or if I no longer meet eligibility requirements for the Direct Deposit program, I understand the State Controller's Office may terminate my enrollment in the program. If any action taken by me results in nonacceptance of a direct deposit by the designated financial institution, I understand that the State assumes no responsibility for processing a supplemental salary or wage payment until the amount of the nonaccepted deposit is returned to the State by the financial institution.	
<input type="checkbox"/> I hereby cancel my Direct Deposit authorization.	SIGNATURE _____ DATE _____

SECTION D (To be completed by state agency or campus personnel/payroll office only)

1. AGENCY NAME	2. AGENCY CODE	3. UNIT CODE
4. REMARKS		5. AUTHORIZED AGENCY SIGNATURE
FOR SCO ONLY 1. EFFECTIVE DATE MO. DAY YR.		I HEREBY CERTIFY THAT I AM THE DULY APPOINTED, QUALIFIED AND ACTING OFFICER OF THE HEREIN NAMED AGENCY AND THAT, BEING SO AUTHORIZED, DO CERTIFY THAT THIS EMPLOYEE IS ELIGIBLE FOR DIRECT DEPOSIT.
		DATE RECEIVED IN EMPLOYING OFFICE MO. DAY YR.
		TELEPHONE NUMBER <input type="checkbox"/> CHECK IF ATSS ()



State of California
Dental Program
AFFIDAVIT OF ELIGIBILITY
(Economically Dependent Child)

I, _____ understand that the Department of Personnel Administration (DPA) allows for the enrollment of a child (other than natural, adopted or stepchild) who is economically dependent upon me until the child marries or becomes age 23 (whichever comes first).

I further understand that the child must reside with me as a member of my household in a normal parent-child relationship, and that I have responsibility for at least 50% of the child's financial support.

I therefore swear (or affirm), under penalty of perjury, that _____ is my dependent, and resides with me as a member of my household in a normal parent-child relationship, and that I am responsible for 50% or more of his/her financial support and maintenance and that the above-mentioned child is not now, nor ever been married; is not a foster child; is not eligible for or enrolled in dental benefit coverage from any other source. Additional children who meet the above qualifications may be listed on the back of this form.

I recognize this affidavit as a legally binding document and I accept responsibility for notifying my departmental Personnel Office immediately if there are any changes in the child's status as my dependent. I also agree to provide supporting documentation, such as tax, court or notarized custody records when requested by my department or DPA at anytime as long as the child is enrolled on my State-sponsored dental coverage as my eligible dependent.

Employee/Retiree Signature: _____ Date Signed _____

Social Security Number: _____ Employing Agency: _____

City: _____ Daytime Phone Number: () _____

Signature witnessed by me, Notary Public, in and for the County of _____

State of _____ on _____

(Signature of Notary Public)

FOR EMPLOYING AGENCY USE ONLY

Affidavit received on _____ by _____
(Authorized Agency Signature)

The Personnel Office should maintain this document in the employee's personnel file, attached to the agency copy of the Dental Enrollment Authorization (STD. 692). Do not send a copy of affidavit to SCO or DPA.

AFFIDAVIT OF ELIGIBILITY
(Economically Dependent Child)

Additional economically dependent children being enrolled in the Dental Program in accordance with qualifications listed on the front side of this form.

1. _____
2. _____
3. _____
4. _____
5. _____

BENEFICIARY DESIGNATION (CalPERS)

STD. 241 (REV. 2-2001) (PAGE 3)

TO PUBLIC EMPLOYEES' RETIREMENT SYSTEM P. O. BOX 942711, SACRAMENTO, CA 94229-2711		(This Space for CalPERS Use Only)	
		ORIGINAL FORM RECEIVED BY CalPERS ON (Date)	
		ORIGINAL FORM APPROVED BY CalPERS ON (Date)	
FROM	MEMBER'S FULL NAME (Please print)	CURRENT EMPLOYER	
	SOCIAL SECURITY NUMBER	BIRTHDATE	TELEPHONE NUMBER

PRIMARY BENEFICIARIES

I hereby designate the following person(s) who survive me as BENEFICIARIES for Death Benefits under the Public Employees' Retirement Law in the event of my death prior to retirement. I understand that if I die after becoming eligible for service retirement, this beneficiary designation may be superseded in certain cases and benefits paid according to law to my eligible surviving spouse or minor children; or, if my death is determined to be industrial, special death benefits will be paid in the manner prescribed by law. If no percentage (%) is given, benefits will be paid SHARE AND SHARE ALIKE. ***I may limit the amount payable to my spouse and name another beneficiary by submitting a Special CalPERS Beneficiary Designation form (STD. 241S).**

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(ZIP Code)
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(ZIP Code)
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(ZIP Code)

SECONDARY BENEFICIARIES

In the event I survive the person(s) named above, I hereby designate the following person(s) who survive me, as BENEFICIARIES. If no percentage (%) given, benefits will be paid SHARE AND SHARE ALIKE.

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(ZIP Code)
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (Number and Street)		(City)		(State)	(ZIP Code)

Should I survive all of the persons named above, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to the Board of Administration, all in accordance with the applicable provisions of law.

BY THIS BENEFICIARY DESIGNATION, I HEREBY REVOKE ANY PREVIOUS DESIGNATION I HAVE FILED. I UNDERSTAND THAT MY MARRIAGE, INITIATION OF DISSOLUTION OR ANNULMENT OF MY MARRIAGE, OR THE BIRTH OR ADOPTION OF A CHILD SUBSEQUENT TO THE DATE I EXECUTE THIS FORM WILL AUTOMATICALLY VOID THIS DESIGNATION.

MEMBER		SPOUSE	
SIGNATURE (Member's Full Name)	DATE	By signing this beneficiary designation form, I acknowledge the information entered by my spouse.	
ADDRESS (Number and Street)		SPOUSE'S SIGNATURE (IMPORTANT - if no signature or certification, the attached BSD-800 must be completed)	
(City)	(State) (Zip Code)	WITNESS (Cannot be a beneficiary)	
		WITNESS' SIGNATURE	
<input type="checkbox"/> I certify under penalty of perjury that I am not legally married (never married, divorced, widowed).			

BENEFICIARY DESIGNATION (CalPERS)

STD. 241 (REV. 2-2001) (PAGE 1)

INFORMATION AND INSTRUCTIONS
PLEASE READ CAREFULLY

- I. If you die before you retire, the Public Employees' Retirement Law provides for payment of specific Death Benefits to your surviving beneficiaries. Please see your personnel officer for a description of the benefits. The benefits are payable to the following beneficiaries:
 - A. **If you are eligible for retirement on date of death or if you are a State member with at least 20 years of State service credit**, the benefits will be payable to your surviving spouse to whom you have been married for either one year or prior to the onset of the injury or illness that causes your death (whether or not you were still living together at the time of your death). Or, if you do not have an eligible spouse, to your unmarried children under age 18. [Note: If you are married and are either eligible for retirement or are a State member with at least 20 years of State service, you may limit the benefit payable by law to your spouse and name a different beneficiary(ies) to receive a portion of the lump sum benefit. If you wish to do this, you must obtain the "Special CalPERS Beneficiary Designation" form (STD. 241S) available from your personnel office or by calling CalPERS at (800) 352-2238.]
 - B. **If you are a safety or industrial member and your death is determined to be industrial**, the benefit will be payable to your surviving spouse (whether or not you were still living together at the time of your death) or, if none, to your unmarried children under age 22.
 - C. If A and B do **not** apply and there is no valid Beneficiary Designation on file at the time of death, the benefits will be payable to your survivors in the following order: **(Note: If you want your benefits paid to the survivors as listed below, you DO NOT need to complete the Beneficiary Designation form.)**
 1. Your surviving spouse (whether or not you were still living together at the time of your death); or, if none,
 2. Natural and adopted children, including a natural child adopted by another, share and share alike; or, if none,
 3. Parents, share and share alike; or, if none,
 4. Brothers and sisters, share and share alike; or, if none,
 5. Your estate (if probated, or subject to probate), or, if not,
 6. Your trust (if one exists), or, if not,
 7. Stepchildren, share and share alike; or, if none,
 8. Grandchildren, including step-grandchildren, share and share alike; or, if none,
 9. Nieces and nephews, share and share alike; or, if none,
 10. Great-grandchildren, share and share alike; or, if none,
 11. Cousins, share and share alike.
 - D. If A and B do not apply and there **is** a valid Beneficiary Designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form. **However, if you are legally married and designate someone other than your spouse, your spouse may still be entitled to his/her community property interest in the death benefits.**
- II. Please use the attached Beneficiary Designation if you wish to designate beneficiaries other than the statutory beneficiaries shown above, or in a different order. You may designate or change the beneficiaries you name at any time if the circumstances described in Part I, A & B do not apply.
 - A. You may name as beneficiary any person or persons, your estate or a corporation. (A corporation must be incorporated under the laws of a state.)
 - B. You may designate a trust as your beneficiary. However, if you wish to designate a trust, the following information should be provided: The name of the trust, date of trust, and name and address of the person with whom the trust is on file.
 - C. Do **not** name a guardian for a minor child. If the money is payable to a minor child, the court-appointed guardian will be responsible for any benefits paid to the child. **(Note: A parent who has custody of a minor child is not required to be appointed by the court as guardian in order to claim a benefit on behalf of their child.)**
- III. Your Beneficiary Designation will be revoked automatically by any of the following events:
 1. Marriage; or
 2. Dissolution or annulment of marriage if **initiated after** the beneficiary designation form was submitted; or
 3. Birth or adoption of a child; or
 4. Termination of employment that results in a refund of your contributions.

If your designation is revoked by one of the above events, benefits will be paid to your statutory beneficiaries as shown in Section 1 above, unless you submit a new Beneficiary Designation.

Please refer to your CalPERS Member Booklet for further details on the above pre-retirement death benefits. A copy of the booklet may be obtained from your personnel office, from your nearest CalPERS office, or by calling (800) 352-2238.

INSTRUCTIONS**SEE REVERSE SIDE OF THIS PAGE**

BENEFICIARY DESIGNATION (CalPERS)

STD. 241 (REV. 2-2001) (REVERSE, PAGE 1)

INSTRUCTIONS

1. Press firmly and print clearly with ball point pen or type all information requested. If you make an error, make the necessary correction (do not use correction fluid) and initial the change.
2. Prepare a rough draft list on scratch paper of whom you wish to name, the relationship, social security number and complete address. (The name must be the full given name, as "Mary Jane Smith"; not, "Mrs. John Edward Smith.")
3. Enter on the form the full names of your beneficiaries, relationship, social security number and the complete address for each. (If this form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries.)
4. You must sign the form in the presence of a witness (other than a named beneficiary) with your full name, as "John Edward Smith".
5. Your spouse must sign the form, in the presence of a witness, to acknowledge the names of the beneficiaries you are designating. **IMPORTANT** –If you are unable to obtain your spouse's signature, you **MUST** complete and return the BSD-800, Justification for Non Signature of Spouse form included in this packet.
6. Have the witness clearly sign the form.
7. Enter the date you signed the form and your current mailing address.
8. Mail original and duplicate of the completed form to the California Public Employees' Retirement System at the address shown.
9. After review and processing, the approved member copy will be returned within six weeks for your records.

PLEASE NOTE:

Your Beneficiary Designation **CANNOT** be processed without either your spouse's signature, or the completed "Justification for Non Signature of Spouse" (BSD-800) form attached. The Beneficiary Designation may be invalid if the form is not dated or if corrections/erasures are not initialed. The effective date of the Beneficiary Designation is the date the completed form is received by the Retirement System.

IMPORTANT INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000, et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Failure to supply all of the requested information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to: state and public agency employers, California State Attorney General, Office of the State Controller, Teale Data Center, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare microfiche/microfilm for CalPERS. Disclosure to these parties is done in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the California Public Employees' Retirement System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P. O. Box 942702, Sacramento, CA 94229-2702.



Health Benefit Services Division
P.O. Box 942714
Sacramento, CA 94229-2714
(HBD-35)

PUBLIC EMPLOYEES' RETIREMENT SYSTEM
HEALTH BENEFIT SERVICES DIVISION
ELIGIBILITY AUDIT UNIT

AFFIDAVIT OF ELIGIBILITY
(Economically Dependent Child)

The Public Employees' Medical and Hospital Care Act (PEMHCA) allows for the enrollment of a child (other than natural, adopted or stepchild), in a CalPERS-sponsored health plan when the employee or annuitant assumes the responsibilities of the child's parent (a parent-child relationship) and assumes financial support for the child. The child must be unmarried and under the age of 23.

I, therefore, swear (or affirm) under penalty of perjury that _____ (dependent's name), who was born on _____ (date of birth) is my dependent, resides with me as a member of my household in a parent/child relationship, and that I am responsible for his/her financial support and maintenance. I also swear (or affirm) under penalty of perjury that the above-mentioned child is not now, nor has ever been married and came to live with me in my household on _____ (date of acquisition).

I recognize that this affidavit is a legally-binding document and accept responsibility for notifying my Health Benefits Officer immediately if there are any changes pertaining to this child's status as my dependent. I also agree to provide supporting documentation, such as tax, court or notarized custody records when requested by PERS or my employer at any time as long as the child is enrolled as my dependent.

Employee/Annuitant Signature: _____

Date Signed: _____ Place: _____ Daytime Phone: (____) _____

Social Security Number: _____ - _____ - _____ Employing Agency: _____

Certificate of Acknowledgment

State of California, County of _____

On _____ before me, _____
(Name and Title) personally appeared _____
personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. WITNESS my hand and official seal.

Signature _____ (Seal)

FOR EMPLOYING AGENCY USE ONLY

Affidavit received on _____, by _____ (Signature of Health Benefits Officer)
(Please return this form to your Personnel Office if you are an active employee. If you are a retiree, please attach this form to your written request.)

(Revised 9/97)



Reply to Section: _____
Refer to: _____

AFFIDAVIT OF MARRIAGE

I DECLARE THAT THE INFORMATION BELOW IS TRUE AND CORRECT:

I AM UNABLE TO SECURE A COPY OF MY MARRIAGE CERTIFICATE.

TO RECEIVE HEALTH BENEFIT COVERAGE THROUGH THE PUBLIC EMPLOYEES' MEDICAL AND HOSPITAL CARE ACT PROGRAM, I CERTIFY THAT ON THE

____ DAY OF _____, IN THE YEAR 19____,
(Day of Month) (Month)

IN THE STATE OF _____,

THAT I, _____, WAS LEGALLY AND
(Please print name)

CEREMONIALLY MARRIED TO _____.
(Spouse's Name)

SIGNATURE OF PRINCIPAL

ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of _____, county of _____,

on _____, before me, _____,

personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instruments the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

Witness my hand and official seal.

Signature of Notary Public

(Seal)